Documents for the Record

Subcommittee on Health Hearing

Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms.

May 20, 2026

Majority:

1. May 19, 2026, statement by the American Clinical Neurophysiology Society.
2. May 19, 2026, statement by the American Pharmacists Association.
3. May 20, 2026, statement by the American Society of Hematology.
4. May 19, 2026, statement by the American Physical Therapy Association.
5. May 19, 2026, statement by the American Medical Association.
6. May 20, 2026, statement by the American Academy of Dermatology Association.
7. May 20, 2026, statement by the Association of American Medical Colleges.
8. May 20, 2026, statement by the Society of Gynecologic Oncology.
9. May 20, 2026, statement from the Endocrine Society.
10. May 20, 2026, statement by the Alliance for Specialty Medicine.
11. May 20, 2026, statement by the Association of Black Cardiologists (ABC).
12. May 19, 2026, letter from American Alliance of Orthopedic Executives.
13. May 20, 2026, statement from American Society for Radiation Oncology.
14. May 20, 2026, statement from Premier Inc.
15. May 20, 2026, statement from the Association for Clinical Oncology.
16. May 20, 2026, statement by AMGA.
17. May 20, 2026, statement by the American College of Surgeons.
18. May 20, 2026, statement submitted by the Federation of American Hospitals
19. May 20, 2026, American College of Emergency Physicians.
20. May 20, 2026, statement by the American Association of Orthopaedic Surgeons.
21. May 20, 2026, statement by the Medical Group Management Association.
22. May 20, 2026, summary of statement by the American College of Surgeons (summary of #17).

Minority:

1. May 20, 2026, letter to Chair Griffith and Ranking Member DeGette by the Connected Health Initiative.
2. May 20, 2026, letter to Chair Griffith and Ranking Member DeGette by the American College of Emergency Physicians.
3. May 20, 2026, statement by the American College of Surgeons.
4. My 20, 2026, second statement by the American College of Surgeons.
5. May 20, 2026, statement by the American Hospital Association.

6. May 20, 2026, letter to Chair Guthrie, Chair Griffith, Ranking Member Pallone, and Ranking Member DeGette by the Alliance of Specialty Medicine.
7. May 20, 2026, statement by FamiliesUSA.
8. May 20, 2026, letter to Chair Guthrie and Ranking Member Pallone by the Connected Health Initiative.
9. May 20, 2026, statement by the Primary Care Collective.
10. July 2022, article from J. Gen Intern Med.
11. May 19, 2026, statement by the American Physical Therapy Association.

Statement for the Record
Submitted by the American Clinical Neurophysiology Society
re: the House Energy and Commerce Health Subcommittee Hearing on Examining Medicare Physician Payment, MACRA and Opportunities for Payment Reform
May 19, 2026

The American Clinical Neurophysiology Society (ACNS) appreciates the opportunity to submit this statement for the record for today's hearing on Medicare physician payment reform and opportunities for payment reform. ACNS is supportive of the bipartisan efforts underway to address longstanding challenges within the Medicare physician fee schedule and to modernize the Medicare Access and CHIP Reauthorization Act (MACRA).

Founded in 1946, ACNS is a professional medical society representing more than 1,600 physicians, researchers, and allied health professionals dedicated to advancing excellence in clinical neurophysiology. Our members diagnose and treat patients with complex neurologic conditions using technologies such as electroencephalography (EEG), electromyography (EMG), nerve conduction studies, intraoperative monitoring, sleep studies, and related neurophysiologic techniques. Many of the patients served by ACNS members are Medicare beneficiaries, making a stable and sustainable Medicare physician payment system critically important to preserving patient access to specialized neurological care.

ACNS strongly supports the Committee's bipartisan focus on physician payment reform and urges Congress to act this year to stabilize and improve the Medicare physician payment system. The current system is unsustainable for both patients and providers. Repeated payment reductions, combined with rising practice costs, inflationary pressures, and increasing administrative burden, are placing enormous strain on physician practices across the country. While hospitals and other providers receive regular payment updates tied to inflation, physicians continue to face stagnant reimbursement and annual uncertainty surrounding payment cuts. Furthermore, the conversion factor has changed very little in 30 years; in 1998, the conversion factor was $36.6873 and in 2026, the conversion factor was $33.4009 for the non-APM conversion factor.

The cumulative impact of chronic underpayment is increasingly threatening patient access to care. Physician practices are struggling to absorb escalating costs associated with staffing, technology, compliance, supplies, and facility operations. For many practices, these financial pressures are no longer manageable. As a result, physicians are being forced to reduce services, limit Medicare participation, delay investments in innovative care delivery, or close practices altogether.

At the same time, inadequate physician reimbursement is accelerating consolidation throughout the healthcare system. Independent physician practices are increasingly being acquired by hospitals and large health systems because physicians cannot remain financially viable under the current Medicare payment structure. This trend has significant implications for patients, including reduced competition, higher healthcare costs, and fewer

choices for care in local communities. Consolidation is particularly harmful in highly specialized fields such as clinical neurophysiology, where patients often rely on access to community-based specialists for timely diagnosis and treatment of complex neurological conditions.

ACNS believes Congress must address the structural flaws in MACRA that have contributed to this instability. While MACRA successfully repealed the Sustainable Growth Rate (SGR) formula and sought to incentivize value-based care, the law has failed to incentivize value-based care with far fewer physicians in advanced alternative payment models as envisioned by the authors of MACRA and exacerbated the downward pressure on physician reimbursement. The statutory budget neutrality requirements and the absence of an adequate inflationary update mechanism continue to create annual payment instability and uncertainty for physicians.

We urge Congress to pursue reforms that:

- Provide physicians with predictable annual payment updates tied to inflation and practice cost growth;
- Address or reform budget neutrality requirements that trigger harmful across-the-board payment reductions;
- Update the conversion factor based on Medicare Economic Index (MEI) and update practice expense data on a regular basis to accurately reflect the true costs of providing care;
- Reduce unnecessary administrative burden within the Quality Payment Program (QPP);
- Improve the design of MIPS and alternative payment models so these programs are meaningful, specialty-relevant, and have achievable goals without creating administrative burden for physician practices of all sizes; and
- Support physician participation in value-based care models without imposing excessive financial risk or reporting complexity.

ACNS also emphasizes that physician payment reform is fundamentally about preserving patient access to care. Patients cannot benefit from innovations in healthcare delivery if there are insufficient physicians able to provide those services. Neurologic disorders are often chronic, progressive, and time-sensitive, requiring highly trained specialists and advanced diagnostic testing. Ensuring adequate reimbursement for these services is essential to maintaining healthcare access for Medicare beneficiaries.

We commend the Committee for approaching these issues in a bipartisan manner and for recognizing the urgent need for action. Physicians across specialties have faced years of instability and uncertainty under the current system, and patients are increasingly experiencing the downstream effects through workforce shortages, longer wait times, and reduced access to independent specialty care.

ACNS strongly encourages the Committee to continue working on a bipartisan basis to enact meaningful physician payment reform this year, that creates long-term stability, supports independent physician practices, advances value-based care, and protects patient access to high-quality specialty services.

Thank you for the opportunity to submit this statement for the record and for your leadership on this important issue.

APhA
American Pharmacists Association

May 19, 2026

The Honorable Brett Guthrie
Chairman
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Morgan Griffith
Chairman, Subcommittee on Health
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

RE: "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reform" Hearing

Dear Chairman Guthrie, Chairman Griffith, and Members of the Health Subcommittee,

The American Pharmacists Association (APhA) appreciates the opportunity to provide comments on the Health Subcommittee's hearing, "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms."

APhA represents pharmacists, student pharmacists, and pharmacy technicians in all practice settings, including but not limited to community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

Reforming Current Procedural Terminology (CPT) Coding

Oversight and Government Reform Committee Chairman James Comer's April 30, 2026, letter to CMS raises a fundamental issue that Medicare and Medicaid depend on a privately owned, licensed coding system, the CPT system, raising concerns about transparency and accountability in how federal health care dollars are allocated.[1] Chairman Comer highlights

[1] *James Commer Letter to CMS Administrator Mehmet Oz Regarding CPT Coding System Oversight*, U.S. House Committee on Oversight and Government Reform (April 30, 2026). Available at: https://oversight.house.gov/wp-content/uploads/2026/04/CPT-Code-letter-to-CMS-.pdf.

how the scale and complexity of CPT, now exceeding 7,800 codes, can contribute to high-severity billing, which has grown to represent about 40 percent of Medicare inpatient cases. At the same time, enforcement actions continue to recover billions in payments each year.[2]

Taken together, these concerns reinforce the need for reform. A system that is both highly complex and privately controlled, while also linked to persistent fraud risks, is not sustainable. Simplifying coding, improving transparency, and reassessing reliance on the current CPT framework should be central to ensuring Medicare serves patients, providers, and taxpayers effectively.

The HHS Secretary has also expressed interest in reducing the big physicians' lobby's monopoly over medical billing codes and its clear conflict of interest/financial interests in the current, broken system.[3]

APhA submitted comments to the Senate Committee on Health, Education, Labor, and Pensions (HELP Committee) in response to its request for information on CPT coding and its impact on health care costs. APhA stressed that one of the big physicians' lobby's top policy issues is the inaccurate claim that mid-level practitioners, such as pharmacists, are not qualified to treat patients without physician oversight,[4] despite years of documented, clear, and undisputed evidence of pharmacists' state-based authority, extensive training and education,[5] positive impact on patient outcomes,[6] and return on investment.[7] The big physician lobby continues to

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[2] *Id.*

[3] *RFK Jr. Wants to Change How Medicare Pays Doctors*, Advisory Board (Jan. 2, 2024). Available at: https://www.advisory.com/daily-briefing/2024/12/02/rfkjr-medicare-payments.

[4] *Advocacy in Action: Fighting Scope Creep*, American Medical Association (Mar. 11, 2025). Available at: https://www.ama-assn.org/practice-management/scope-practice/advocacy-action-fighting-scope-creep.

[5] Pharmacist, Mayo Clinic College of Medicine and Science. Available at: https://college.mayo.edu/academics/explore-health-care-careers/careers-a-z/pharmacist/ (noting that pharmacists must earn a PharmD degree, which often takes four years to complete after the completion of at least two years of undergraduate study).

[6] *See* Dave L. Dixon, et al., *Cost-Effectiveness of Pharmacist Prescribing for Managing Hypertension in the United States*, 6 JAMA Network Open e2341408 (2023). Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2811317. *See also* Dave L. Dixon, et al., *Effect of Pharmacist Interventions on Reducing Low-Density Lipoprotein Cholesterol (LDL-C) Levels: A Systematic Review and Meta-Analysis*, 14 Journal of Clinical Lipidology 282 (2020). Available at: https://www.sciencedirect.com/science/article/abs/pii/S193328742030074X. *See also* Rahma M. Alabkal, et al., *Impact of Pharmacist-Led Interventions to Improve Clinical Outcomes for Adults with Type 2 Diabetes at Risk of Developing Cardiovascular Disease: A Systematic Review and Meta-Analysis*, 36 Journal of Pharmacy Practice 888 (2022). Available at: https://journals.sagepub.com/doi/epub/10.1177/08971900211064459.

[7] Armando S. Almodovar, et al., *Return on Investment of Pharmacists' Services Among Non-Hospitalized Patients: A Scoping Review*, 21 Research in Social and Administrative Pharmacy 321 (2025). Available at: https://www.sciencedirect.com/science/article/pii/S1551741125000129.

make these baseless assertions as the country faces a growing physician shortage, a primary care crisis, and skyrocketing health care costs.[8]

As early as 1998, APhA requested that the CPT Editorial Panel allow physicians and others to utilize pharmacists with incident to CPT codes and to include pharmacists as eligible prescribers. The big physician lobby-owned CPT Editorial Panel has consistently stated that it cannot add pharmacists to this list because they are not recognized as health care providers under the Social Security Act. However, this is a constitutional issue as states have primary authority to regulate the practice of health professions. When the CPT Editorial Panel and CMS fail to recognize the state-based authority of pharmacists as health care providers, health systems are reluctant to maximize the use of pharmacists to provide services they are trained and authorized by their states to provide, due to confusion and legal questions arising from pharmacists incorrectly not being recognized as eligible prescribers under the CPT coding system, benefiting the current big physician monopoly over patients' expanded access to care.

Accordingly, APhA encourages the Committee to work with CMS to require the CPT Editorial Panel to allow pharmacists to practice at the top of their license. If the CPT Editorial Panel continues to fail to recognize pharmacists as eligible providers and blocks patients' access to care, CMS has the capability to use HCPCS codes without using the CPT coding system and to create its own billing codes for Medicare and Medicaid, bypassing the CPT coding system.

Pharmacist-Focused Payment Reform

As the country continues to struggle with a worsening primary care shortage, states have enacted legislation to broaden pharmacists' scope of practice to meet patient needs and align with the extensive training pharmacists receive in a Doctor of Pharmacy (PharmD) program.[9] Depending on the state, pharmacists can provide smoking cessation counseling, health and wellness screenings, immunizations, and other preventive care services, as well as disease state and medication management. Additionally, pharmacists in many states can initiate prescriptions for buprenorphine, naloxone, HIV PrEP and PEP, hormonal contraceptives, and oral antivirals across the country. Private and state payors have already recognized pharmacists' expanded roles and the positive return on investment[10] by reimbursing

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[8] *Health Workforce Projections*, Health Resources & Services Administration. Available at: https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand (**noting that the National Center for Health Workforce Analysis estimates an overall shortage of 141,160 physicians in 2038, including a shortage of 70,610 primary care physicians**).

[9] *Health Workforce Projections*, Health Resources & Services Administration. Available at: https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand (noting that the National Center for Health Workforce Analysis estimates an overall shortage of 141,160 physicians in 2038, including a shortage of 70,610 primary care physicians).

[10] Armando S. Almodovar, et al., *Return on Investment of Pharmacists' Services Among Non-Hospitalized Patients: A Scoping Review*, 21 Research in Social and Administrative Pharmacy 321 (2025). Available at: https://www.sciencedirect.com/science/article/pii/S1551741125000129.

pharmacist-provided patient care services. However, Congress has yet to unlock pharmacists' full potential through direct Medicare Part B reimbursement for these services.

The Ensuring Community Access to Pharmacist Services Act (ECAPS), H.R. 3164, sponsored by members of the Subcommittee, and supported by 111 bipartisan colleagues in the House, would maximize the use of our nation's community pharmacists to treat common respiratory conditions by promoting team-based preventive care at community pharmacies at lower costs for our nation's taxpayers and keep Medicare beneficiaries out of expensive emergency rooms. APhA strongly urges the Subcommittee to move swiftly in a markup with consideration by the full Committee to advance this important piece of legislation to ensure America's seniors have access to these vital health care services in dozens of states in almost every congressional district across the country.

Additionally, APhA encourages the Committee to urge CMS to update the Medicare incident to billing framework to recognize the increased role of pharmacists on the health care team. By permitting physicians and NPPs to utilize pharmacist services using the full range of evaluation and management (E/M) codes necessary for team-based care, there will be greater uptake by our nation's pharmacists, leading to better patient outcomes.[11] Congress made clear its intention to CMS regarding pharmacist-provided patient care services in the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations bills, 2023, (H. Rept. 117-403), 2024, 2025 (H. Rept. 118-585), and most recently 2026 (H. Rept. 119-271) report language:

> "Pharmacist-Provided Incident to Physician Services.—The Committee is pleased with CMS's recognition in the calendar year 2021 physician fee schedule (PFS) final rule (FR 84583) that ''pharmacists could be considered QHPs [qualified health care professionals] or clinical staff, depending on their role in a given service,'' and that ''new coding might be useful to specifically identify these particular models of care.'' However, the Committee remains concerned with current CMS PFS requirements restricting physicians' and nonphysician practitioners' (NPPs) utilizing pharmacists under incident to models to bill at the lowest E/M code (99211), with an estimated time commitment of 7 minutes. The Committee understands this restriction has diminished providers' engagement with pharmacists in team-based care models across the country. CMS should consider how to ensure physicians and NPPs can optimize the use of pharmacists. The Committee encourages CMS identify mechanisms to attribute, report, and sustain pharmacists' patient care contributions to beneficiaries in the Medicare Part B program."
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> "Pharmacists and Patient Care Services.—The Committee is aware that certain Medicare Part B services and care frameworks have provisions to include pharmacists and their

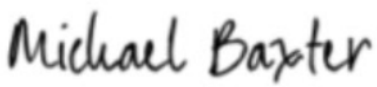
[11] Sara Berg, *Add a Pharmacist to the Team to See Better Outcomes*, American Medical Association (July 6, 2018). Available at: https://www.ama-assn.org/practice-management/scope-practice/add-pharmacist-team-see-better-outcomes.

patient care services. However, CMS has few mechanisms to identify and evaluate the contributions of pharmacists to patient care and outcomes or to identify barriers within current service requirements that prevent the scalable involvement of pharmacists. The Committee encourages CMS to create a mechanism to provide greater visibility into the quality and outcomes of the Medicare services currently provided by pharmacists."

Earlier this month, CMS, ACF, HRSA, and SAMHSA sent a Dear Colleague letter following the Mental Health and Overmedicalization Summit that highlighted the important role of deprescribing in patient care. APhA has requested that CMS leaders and HHS's Healthcare Advisory Committee facilitate this change by using pharmacists. The potential cost savings to the overall health care system are significant (in one study, pharmacists' deprescribing recommendations were accepted 96.7% of the time by the patient's primary care provider and resulted in the potential annualized cost avoidance of $184,221 across 63 patients).[12] Pharmacists make evidence-based recommendations to physicians and other providers to discontinue duplicate or unnecessary medications, substitute medications due to potential adverse effects or known contraindications, and suggest tapering medications that should not be used long-term, as part of routine daily practice. As medication experts, pharmacists are the health care leaders in this area. However, the Medicare billing framework fails to recognize the value of and need for pharmacist-provided services, such as deprescribing, to the overall health care system because it does not permit physicians and non-physician practitioners (NPPs) to bill appropriately for these services.

Thank you for the opportunity to submit comments to the Subcommittee on these important matters. We look forward to working with the Committee to modernize Medicare for the 21st Century. If you have any questions or would like to meet with APhA and our nation's pharmacists, please contact mbaxter@aphanet.org.

Sincerely,



Michael Baxter
Vice President, Government Affairs

[12] Emily Rea, et al., *Pharmacist-Driven Deprescribing Initiative in Primary Care*, 64 Advances in Pharmacy Practice 102161. Available at: https://www.japha.org/article/S1544-3191%2824%2900182-1/fulltext.

American Society of Hematology
Helping hematologists conquer blood diseases worldwide

Statement for the Record
From the American Society of Hematology
For the House Energy and Commerce Committee
Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms
Held on May 20, 2026

The American Society of Hematology (ASH) thanks the House Energy and Commerce ("the Committee") for holding this hearing to examine efforts to reform Medicare physician payment exploring current challenges in the Medicare physician fee schedule and the Medicare Access and CHIP Reauthorization Act, and for the opportunity to submit this statement for the record.

The ASH represents more than 18,000 clinicians and scientists worldwide who are committed to the study and treatment of blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as non-malignant conditions such as sickle cell disease, thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists are pioneers in demonstrating the potential of treating various hematologic diseases and continue to be innovators in the fields of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy. Our mission is to foster high-quality, equitable care, transformative research, and innovative education to improve the lives of patients with blood and bone marrow disorders.

As this Committee knows, inadequate physician reimbursement further increases the strain on the U.S. health care system. For over 30 years, the value of Medicare physician reimbursement has eroded, declining by 33 percent from 2001 to 2026, when adjusted for inflation. During this time, the conversion factor changed very little: set at $31.00 when the Medicare Physician Fee Schedule was implemented in 1992 and only increased by $2 in 34 years to $33.40 today. MACRA provided some relief through statutory updates to the conversion factor, but only from 2015 – 2019. After that, there were no statutory updates to the conversion factor until a differential conversion factor for physicians in participating in the Merit-based Incentive Payment System and Advanced Alternative Payment Models was implemented in 2026. This long period with a lack of positive updates and the MPFS' budget neutrality requirements dictated a series of statutorily required cuts to the conversion factor over the last several years, creating challenges for physicians and their practices as they experienced increased costs delivering care.

Meanwhile, other payment systems under the Medicare program receive annual inflationary updates. Providing payment rate increases to hospitals, skilled nursing facilities, outpatient centers, and ambulatory surgical centers, while withholding comparable updates for the physicians who furnish care in those settings, is unjustifiable. The healthcare system depends on physicians to deliver high quality care to Medicare beneficiaries. Congress must act to create a permanent sustainable payment solution for physicians to continue delivering care to Medicare beneficiaries.

The continued erosion in Medicare physician reimbursement is distinctly acute for hematologists and has accelerated workforce shortages in hematology and other cognitive specialties, limiting access to necessary care for patients across the country. Hematology, particularly classical hematology, is facing

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a severe workforce shortage[1], limiting access to much needed expertise in complex hematological disorders, such as sickle cell disease and thalassemia, as well as complex hematologic malignancies, including leukemias, lymphomas, and myelomas. This shortage is driven by new physicians' concerns of balancing the eroding Medicare reimbursement rates that cover physician and staff salaries, supplies, and equipment, and significant medical school debt. This pressure discourages trainees from entering the field, pushes experienced physicians toward early retirement or to reduce clinical hours, and threatens the sustainability of community-based practices that care for aging and medically complex patients. As access to specialized hematology services declines, patients face longer wait times, fragmented care, and delayed diagnosis and treatment.

At the same time, the practice of hematology is rapidly evolving and becoming increasingly complex, requiring physicians to stay current with the latest innovations as they evaluate and recommend new therapies to their patients, such as recently approved cellular and gene therapies and the expanding availability of bone marrow transplantation. The proliferation of these new and complex therapies comes at a time when the costs of practicing medicine are growing, while Medicare reimbursement, accounting for inflation, is shrinking.

Furthermore, without positive updates to the Medicare Physician Fee Schedule (MPFS) conversion factor, budget neutrality requirements exert even greater downward pressure on Medicare reimbursement and exacerbate the impression that specialties are pitted against one another when new codes are added to the MPFS, or a family of codes is recommended for an increase in valuation, due to the redistributive impacts of other payments under the MPFS. As a result of this, ASH supports efforts to reform budget neutrality requirements, including increasing the outdated budget neutrality threshold of $20 million, and encourages Congress to consult with health economists to determine the most appropriate update.

Additionally, Congress should provide an increase every five years equal to the cumulative increase in the Medicare Economic Index (MEI). By raising the threshold in this manner, redistribution of funds across the MPFS will be more equitable, preempting a cycle of drastic cuts to the conversion factor when new services are added to the MPFS or when high-volume services, like evaluation/management (E/M) services, are revalued.

The American Society of Hematology encourages Congress, on a bipartisan basis, to address these longstanding structural challenges in the Medicare physician payment system. Meaningful reform will require sustained collaboration to ensure Medicare beneficiaries have continued access to high-quality physician services.

Thank you for the opportunity to provide these comments. ASH looks forward to working with the Committee to address administrative and regulatory burdens that contribute to physician burnout and workforce shortages and protect access for aging adults to timely, high-quality care. Should you have any questions or wish to discuss these issues further, please contact Carina Smith at casmith@hematology.org

[1] Go LT, Go LT, Gunaratne MDSK, Wolanskyj-Spinner AP, Ashrani AA, Elliott MA, Godby RL, Hook CC, Padrnos LJ, Pruthi RK, Rivera CE, Rouse RL, Shah S, Shaikh ME, Siddiqui MA, Sridharan M, Wysokinska EM, Go RS, Abeykoon JP. Assessment of classical hematologists and classical hematology fellowship programs at NCI-designated cancer centers. Blood Adv. 2025 Oct 28;9(20):5343-5346. doi: 10.1182/bloodadvances.2025016644. PMID: 40795177; PMCID: PMC12597626.

U.S. House Energy and Commerce Health Subcommittee

Hearing: “Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms”

May 19, 2026

Statement for the Record by the American Physical Therapy Association

3030 Potomac Ave., Suite 100 / Alexandria, VA 22305-3085 / 703-684-2782 / apta.org

Chairman Griffith, Ranking Member DeGette, and Members of the U.S. House Energy and Commerce Health Subcommittee:

On behalf of the approximately 100,000-member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments in response to the Subcommittee's hearing, *"Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms."* APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

"The Economic Value of Physical Therapy in the United States," a recently released APTA report, showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. The report compares physical therapy with alternative care across a suite of health conditions commonly seen within the U.S. health care system. The report underscores the importance of including physical therapists and physical therapist assistants in multidisciplinary teams focused on improving patient outcomes and reducing downstream costs. The committee should consider the insights provided in this report to support access to, coverage of, and payment for physical therapist services in rural and underserved areas, and to support policies that position physical therapists as entry-point providers, ensuring beneficiaries have timely access to proven, cost-effective care, as outlined in our recommendations below.

Background

The 2015 Medicare Access and CHIP Reauthorization Act, known as MACRA, replaced the flawed Sustainable Growth Rate formula with the Quality Payment Program, or QPP. The QPP comprises two tracks: the Merit-based Incentive Payment System, or MIPS, and Advanced Alternative Payment Models, also known as AAPMs. The Centers for Medicare & Medicaid Services (CMS) began implementing the QPP in 2017, with the eventual goal of moving providers out of MIPS and into AAPMs. **There are several foundational**

issues with MACRA and the QPP that disproportionately affect nonphysician-qualified health care providers, such as physical therapists. In addition, there are logistical and operational barriers to therapists participating in MIPS and AAPMs. Some of the current challenges facing therapy providers include:

- **MACRA Has Not Stabilized Payment Under the Medicare Physician Fee Schedule**. MACRA sought to stabilize payments by repealing the Sustainable Growth Rate formula and providing payment adjustments under the QPP. Despite that goal, these changes replaced relief from the growth rate cuts with payment cuts to the conversion factor; as a result, budget neutrality requirements limit the effectiveness of payment incentives provided under MIPS and have required annual legislative intervention to stave off untenable payment cuts. Further, nonphysician providers, including therapists, have few options under the QPP to receive payment adjustments that would otherwise offset payment cuts. **In 2021, the average payment per therapy claim *was the same as it was in 2010*.** Since 2025, therapy services have been further cut due to reductions in the conversion factor. An additional 15% cut to services provided by physical therapist assistants was implemented in 2023. This decrease in payment is simply not sustainable if we are to have a robust workforce that supports access to rehabilitation therapy services nationwide. Providers are suffering from a workforce shortage, and MACRA policies are reducing the resources needed for adequate therapists to meet patient access needs.

- **QPP Does Not Promote Value-Based Care or Effectively Measure Quality of Care**. The QPP does not allow for adequate participation for therapists in either MIPS or AAPMs. The lack of appropriate quality metrics and the failure to include all outpatient therapy providers in MIPS and AAPMs have prevented the shift to value-based care. These problems are compounded by slow, ineffective mechanisms for innovation within the QPP. This means physical therapists who were not fully considered in the QPP's design still cannot meaningfully participate.

- **MIPS Rewards Participation Rather Than Performance.** Because MIPS was created as a budget-neutral program, there is no avenue for all providers to achieve meaningful bonuses, regardless of performance. Payment adjustments in MIPS have been, and remain, deceptively low. In theory, payment adjustments achieved through MIPS were +/- 9% in 2023, the most recent year of available data. The opportunity, however, to earn up to a 9% payment increase (or any high-end increase) is effectively a mirage within this budget-neutral system. The overwhelming majority of

participating MIPS providers receive a positive adjustment (80.86% in 2023), thereby reducing the opportunity for any individual provider to earn high-end bonuses. The highest bonus ever earned under MIPS for a perfect score is still only slightly more than 2%, meaning there is realistically no avenue to achieve meaningful bonuses under MIPS for all providers, and this is even more acute for nonphysicians.

- **Barriers to Therapist Participation in MIPS.** Most physical therapists are not required to participate in MIPS, but are encouraged to opt in to the program. However, extremely limited payment incentives dissuade optional participation, as the cost of compliance outweighs even the highest historical incentives earned under the programs. With a limited PT/OT specialty measurement set and only one therapy cost measure, therapists have few reasons to participate under the program and suffer compounding pay cuts under the MPFS without any opportunity for mitigation through the QPP.

- **CEHRT is a Threshold Barrier for Therapists in MIPS and AAPMs.** Promoting interoperability through Certified Electronic Health Record Technology, or CEHRT, was part of MACRA's original vision. AAPMs promote this by requiring CEHRT as a prerequisite for AAPM opportunities, and, under MIPS, providers are scored on the "promoting interoperability" measure category. CEHRT options are simply not available to physical therapists, as their requirements are costly and burdensome, and many are specific only to physicians. As a result, physical therapists cannot participate in AAPMs and will receive a score of zero under MIPS in the interoperability category. Without vendors working to develop CEHRT for therapists (in part because there are not enough potential users to justify vendors' expense of CEHRT development), these providers will never be able to participate meaningfully. Requirements must be relaxed or modified; otherwise, physical therapists will continue to be assessed on an uneven playing field.

- **Barriers to Participation in AAPMs**. In addition to CEHRT as a threshold barrier to participation, the Qualifying Participant, or QP, threshold to earn incentives under the program, is also not realistically achievable for physical therapists. Further, while there is a Partial QP designation, it does not offer any incentives to participate and serves more to prepare clinicians who believe they would meet the QP threshold in the future. AAPMs could have therapist-specific thresholds or offer incentives for partial QPs to incentivize participation by therapists.

- **Inability of Facility-based Outpatient Therapy Providers to Participate in Bonus Payment Structures.** While outpatient private practice therapy services are paid

under the MPFS, services provided in facility-based settings, such as hospital outpatient departments, rehabilitation agencies, and skilled nursing facilities, are not considered to be a part of the MPFS. Rather, the 1997 Balanced Budget Act required that payments for facility-based outpatient therapy services be "based on" the value of those services as set forth in the MPFS. While therapy services provided under the fee schedule are billed through an individual's National Provider Identifier, all facility-based outpatient therapy services are billed through the facility, and not the individual therapist. This distinction is not insignificant. According to MedPAC, 63% of all Medicare outpatient therapy services are provided in facility-based settings, yet facility-based outpatient therapy providers have had no way to receive payment updates or bonus payments. However, these services are subject to budget neutrality cuts and any other policy affecting therapy payments through the physician fee schedule – such as the multiple procedure payment reduction, also known as MPPR, and cuts to services provided by physical therapist assistants.

Recommendations to Reform MACRA to Allow Broader Participation by Therapy Providers:

Within MACRA, the QPP has posed significant challenges to nonphysician providers. Physical therapists, in particular, have struggled to meaningfully participate in MIPS or engage in AAPMs, in part because CMS has failed to pilot or implement several alternative payment and delivery models applicable to therapy providers. Congress must enact meaningful reforms to the QPP that specifically recognize the value of therapy providers and allow them to provide effective oversight of the QPP to determine its effectiveness at measuring therapy performance and outcomes.

The value of any quality program depends on the ability of all providers to participate. Given the complex and unique challenges faced by physical therapists under QPP, including limited opportunities for therapists' participation in the program, APTA offers the following recommendations to Congress to improve the QPP:

- **Congress Should Authorize a Therapy QPP Reform Workgroup.** As part of any reforms to QPP, Congress should authorize a therapy stakeholder workgroup under the Department of Health & Human Services, comprised of representatives of nonphysician therapy providers (PT, OT, SLP), to identify barriers specific to therapy providers and develop specific recommendations for the Secretary of the Department of Health and Human Services to adopt via rulemaking. APTA has

drafted proposed legislative language that would implement this recommendation; please see Appendix A.

- **Make MIPS Participation Voluntary for Physical Therapists until Meaningful Changes are Made.** There is no immediate path to meaningful participation for all physical therapists without foundational and timely modifications to the cost measure development process and the PT/OT measure set. Currently, physical therapists have only one cost measure available to them, and it applies to fewer than 50% of them. For now, we ask CMS to consider a more equitable approach for physical therapists: to make participation voluntary until additional cost and quality measures are developed and included in the program. There is, simply put, no equitable way forward under the current system, and the authorizing statute for the MACRA does not require PT participation in the program. Until measures appropriately distinguish between high-value and low-value care, financial support is provided for the integration of CEHRT, the contribution of PTs to patients' outcomes is accounted for, and PTs should not be expected to participate in the program. At this point, physical therapists only view the QPP as an obligation with practically no upside. It is an administrative burden that is not designed or currently capable of measuring physical therapists' actual impact on patients. Until more financial and structural investments are made to ensure nonphysicians can be accurately assessed and measured by the QPP, most will seek any means to be exempt from the program.

- **Advance Value-Based Care Models that Recognize the Value of Physical Therapist Services.** Effective quality programs engage numerous health care providers, not just physicians. To demonstrate the ability of non-physician providers to engage in and even lead value-based care, **APTA has created an Alternative Payment Model that addresses frailty by incorporating physical therapists into a patient's primary care team.** In the model, potential patients are screened for frailty, and those identified as frail or pre-fail receive a functional assessment by a physical therapist, including the Short Physical Performance Battery and the PROMIS Physical Function SF 10a. The combination of these assessments provides a functional profile of the individual as well as a risk assessment for adverse events, including falls, ED visits, hospitalizations, morbidity, and mortality. Once a functional baseline is established, a plan is developed and implemented in collaboration with the individual and any involved caregivers. This plan may include referral for skilled physical therapy. Alternatively, or concurrently, the plan addresses safety issues and

connects the individual with evidence-based programs in the home, virtually, and/or in the community. The tests are readministered at 30 days, 60 days, 90 days, and 180 days, and then annually to track the individual's status and modify the program as needed. Key to the success of the model is the use of a physical therapist to address the physical and functional components of frailty. As Congress evaluates the future of value-based care, APTA urges Congress to consider the frailty of APM and other models that employ non-physician providers.

Other Recommendations to Reform the Medicare Physician Fee Schedule:

- **Eliminate the Multiple Procedure Payment Reduction Policy**. The MPPR Policy, first implemented in 2011, applies to physical therapy, occupational therapy, and speech-language pathology services provided under Medicare Part B. Because of MPPR, when therapists bill more than one "always therapy" service (identified by CPT code) on the same day for the same patient, all therapy services beyond the first are subject to a reduction in the practice expense portion of that code.

  Under this policy, the therapy service with the highest practice expense value is reimbursed at 100%, and the practice expense values for all subsequent therapy services, provided by all therapy clinicians, are reduced by 50%. The work and malpractice components of the therapy service payment are not reduced. In the 2011 Medicare Physician Fee Schedule, CMS first proposed the implementation of a 25% MPPR across therapy services. Congress reduced this reduction amount to 20% in the Physician Payment and Therapy Relief Act of 2010 (H.R. 5712). This 20% MPPR was in place from Jan. 1, 2011, to March 31, 2013. Without any further analysis demonstrating a need to increase the MPPR, Congress implemented a permanent 50% MPPR in the American Taxpayer Relief Act of 2012, which was implemented by CMS on April 1, 2013. The average payment per therapy claim in 2013 (after MPPR) was 8.5% less than the average therapy claim in 2010 (before MPPR).

  APTA has opposed the MPPR policy since its inception. It is inherently flawed because the American Medical Association Relative Value Scale Update Committee, which assigns values to CPT codes, already ensures that any potential duplication in work or practice expense is addressed as part of the code valuation process. Certain efficiencies that occur when multiple therapy services are provided in a single session were explicitly taken into account when relative values were established for these

codes. The application of MPPR to the "always therapy" codes results in duplicative and excessive reductions of these codes and has a significant impact on the financial viability of therapy practices, ultimately affecting access to vital therapy services.

The percentage of payment reduction was arbitrarily determined by the 112th Congress and does not reflect actual utilization data on how many units of a therapy service are typically delivered in a treatment session, nor does it recognize that OT, PT, and SLP interventions are separate and distinct. When CMS first proposed the MPPR, they purposefully did not consider how therapy services are provided in facility-based settings, even stating that they did "not believe it would have been appropriate for us to consider institutional patterns of care." (See page 70).

With the potential exception of greeting the patient, clinical staff activities that are elements of the practice expense are not duplicative in nature and should not be reduced in value, especially when delivering different services during the therapy session. For instance, if therapeutic exercises using hand weights are provided for one unit, followed by self-care retraining in the kitchen for one unit, then the equipment, supplies, and clinical staff activities are entirely separate for each of these procedures. Each requires its own disinfection, patient positioning, and other set-up and clean-up processes before and after the procedure. Under the current policy, despite those services being separate and distinct, and having a separate and distinct practice expense, payment for the second unit is reduced even though the values of the two codes do not include any duplicative cost.

MPPR also applies across therapy disciplines delivered on the same date, regardless of the distinct services and supplies provided to the patient. While the first therapy discipline (e.g., physical therapy) would receive payment under MPPR at 100% for the first unit and 50% of the practice expense for all other units, a second or third discipline (e.g., occupational therapy or speech-language pathology) delivering services on that date would have all provided service units reduced. This occurs even though the expertise, equipment, clinical staff, and supplies utilized for one therapy service have no overlap with the other services provided. This policy penalizes providers when scheduling multiple therapies on the same date, which disproportionately affects beneficiaries in rural and underserved communities where transportation issues may require therapy services to be delivered on the same day

to reduce the need for repeat visits to the clinic. **APTA supports the RECOVER Act (H.R. 8386) legislation that would repeal the flawed MPPR policy.**

- **Provide Improved Transparency in the CPT Code Valuation Process.** The work of the American Medical Association Relative Value Scale Update Committee, or AMA RUC, is, in essence, the work of a federal advisory committee but is not subject to the requirements of the Federal Advisory Committee Act. Congress could make the RUC valuation process subject to this act or could create a specific set of transparency requirements specifically for the RUC. AMA confidentiality agreements and related restrictions should only be limited to voting details and should not apply to valuation surveys, policies, procedures, any other data collection, or debate. The lack of transparency in the AMA RUC processes used for CPT code valuation, and during the debate before a vote, creates a system that is easily politicized, potentially pits different health care specialties against one another in a fight over funds limited by budget neutrality, and makes it difficult to report concerns outside the process.

- **Congress Should Separate High-Value Procedures from the RUC Process and Remove These Procedures from Calculations of Budget Neutrality Under the Medicare Fee Schedule.** Since the establishment of the current relative value unit and rate-setting process, there has been a major shift in the services provided in outpatient settings. Services that used to be provided in the hospital under Medicare Part A are now being provided in outpatient settings under Medicare Part B. This increase in high-tech, high-cost services that used to be reimbursed under Part A is skewing relativity and squeezing lower-cost specialties because of budget neutrality.

- **Direct CMS to Exercise Greater Oversight of the CPT Code Valuation Process.** The process for valuing CPT codes is labor-intensive, complicated, and nuanced. The AMA RUC has developed the expertise to administer this process over more than 30 years. Despite this expertise, CMS sometimes rejects the RUC and RUC HCPAC recommendations, choosing to undervalue or not value codes that have gone through this extensive, complex AMA valuation process. This process requires dozens of hours of specialty society staff time as well as expert advisor time to prepare and present at numerous meetings for various stakeholders, including the Practice Expense Workgroup, the Research Subcommittee Workgroup, and the Relativity Assessment Workgroup, among others. CMS must be a stronger leader in the process and must exercise its oversight authority to ensure that, if it continues to place such extensive time and resource burdens on specialty societies, the code values put forward by the RUC are accepted by CMS.

To this end, Congress should direct CMS to do the following:

1. CMS should play a stronger role in the development of the rules and procedures used during the valuation and data collection process. This will help to ensure that CMS has the expertise on staff to confirm that policies and procedures are followed, provide appropriate oversight, and guarantee that the process is reflective of and equitable for all specialties that CPT codes for health care services.
2. CMS should establish an external appeals process that can be triggered before values are published in the Medicare Physician Fee Schedule proposed rule. For this reason, we support the reinstatement of a refinement panel. Currently, if CMS chooses to simply not value a code, or if CMS undervalues a code compared to the RUC recommendation, there is no process of appeal, except to submit a comment during the public comment period of the fee schedule proposed rule. This is an inadequate way to challenge a decision, given the complexity and time-intensive nature of the valuation process.
3. CMS should clarify how the list of reference codes (used for the purpose of establishing future relative values) should be developed. The reference list plays a crucial, but opaque, role in setting relative values.
4. CMS should develop an independent advisory panel to examine existing issues in the valuation process, analyze trends that might inappropriately skew relative values, and suggest ways the process may need to evolve to account for continued changes in the health care landscape, including innovations. For example, the current valuation process disincentivizes building in efficiencies to medical services, as those services are then devalued under the current process. Congress should give CMS the flexibility to implement the recommendations of such a panel.

Centers for Medicare and Medicaid Services (CMS) RFI: "Unleashing Prosperity Through the Deregulation of the Medicare Program."

As members of the Subcommittee are aware, last year, CMS published an RFI ("Unleashing Prosperity Through the Deregulation of the Medicare Program)" seeking input regarding current regulations that may be burdensome, outdated, or unnecessary, and should be reviewed for potential elimination or significant modification. In response to the RFI, APTA submitted extensive comments recommending the following measures

be implemented to better aid in the delivery of healthcare to Medicare patients and ease administrative burdens on providers:

- **Replace Medicare's 8-Minute Rule.** Under Medicare's 8-Minute Rule, introduced in Dec. 1999, rehabilitative therapists are required to add all service minutes across different CPT codes during a therapy session and apply a tiered decision matrix to determine unit billing. The rule is both confusing and time-consuming; the instructions and examples on applying the policy cover three pages in the Medicare Claims Policy Manual and are an oft-cited source of significant strain and uncertainty among therapy providers. APTA urges adoption of the AMA's Midpoint rule, a similar, but administratively simpler standard. Under the Midpoint Rule, each timed service is evaluated individually based on its time threshold, simplifying calculations and reducing billing errors.

- **Expand the Plan of Care Signature Exception to Direct Access Patients.** Previously, in addition to submitting the plan of care (POC) to the referring provider within 30 days of initial treatment, a PT was required to have that provider return a signed and dated copy of the POC as evidence of certification. However, in the CY 2025 Physician Fee Schedule rule and codified under the new 424.24(c)(5), once the PT has transmitted the POC, the onus is now on the referring provider to either return the signature or indicate changes. However, one major caveat is that only claims for services provided to patients with an order or referral are eligible for the exception. APTA recommends that this policy be expanded and applied to direct access patients to expedite the delivery of care.

- **Eliminate Enforcement of the KX Modifier.** Section 50202 of the Bipartisan Budget Act of 2018, P.L. 115-123 amended Section 1833(g) of the Social Security Act to repeal the application of the therapy caps. While APTA supported this removal, in lieu of the caps, Congress added limitations to the delivery of therapy services via the KX modifier threshold. Despite the removal of the hard cap on payment for therapy services, the SSA still requires the KX modifier to be appended to any claims exceeding the KX threshold, which is adjusted annually for inflation using the Medicare Economic Index. For physical, occupational, and speech therapists, if services delivered in a year exceed the annual threshold amount, the therapist must include the KX modifier on the patient's claims to confirm that services were medically necessary and are justified by the appropriate documentation. Claims for services over the KX modifier threshold amounts without the KX modifier are denied. Appending the KX modifier to

claims to support medical necessity for the purposes of payment is redundant and should no longer be enforced.

- **Create Consistent and Uniform Credentialing Procedures in Medicare Advantage:** Under 42 CFR 422.204, a Medicare Advantage Organization (MAO) is required to have written policies and procedures for the selection and evaluation of providers for network participation and follow this documented process with respect to initial credentialing. Likewise, commercial and other health plans are required under state law to follow similar requirements, essentially requiring the same information and data points from providers who enter into contracts to participate in their networks. Physical therapists credentialed by Medicare, therefore, undergo redundant credentialing by each MAO or other health plan they contract with for network participation. In addition to the extensive wait time and resulting impediment to access to care, physical therapy practices and facilities expend significant time and resources managing multiple credentialing applications, all collecting essentially the same duplicate documentation. Applying Medicare credentialing recognition across all MAOs and commercial insurance plans would result in faster patient access, lower administrative costs, greater provider mobility, improved continuity of care, and more robust networks in underserved areas

Conclusion

APTA appreciates the Subcommittee holding this hearing and for the opportunity to provide comments on these issues. Should you have any questions, please contact Steve Kline with APTA Congressional Affairs (stevekline@apta.org). Thank you for your time and consideration.

Sincerely,

Justin Elliott
Vice President, Government Affairs
American Physical Therapy Association

Appendix A: Recommended Draft Legislative Language to Reform QPP to Allow Broader Participation by Therapy Providers

SEC. 5. REFORMS FOR THERAPY PROVIDERS UNDER MACRA

SECTION 1848(K) OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395W-4) IS AMENDED BY INSERTING THE FOLLOWING:

(3) QUALITY MEASURES FOR USE BY PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS, OR A QUALIFIED SPEECH-LANGUAGE PATHOLOGISTS. —

(I) IN GENERAL. – THE SECRETARY SHALL ENSURE THAT ADEQUATE MEANINGFUL MEASURES ARE AVAILABLE FOR REPORTING BY REHABILITATION THERAPISTS FOR DIAGNOSES OR CONDITIONS EVALUATED, TREATED, AND MANAGED BY REHABILITATION THERAPISTS AND THAT THOSE MEASURES ARE NON-PROPRIETARY, CAN BE INTEGRATED INTO A VARIETY OF ELECTRONIC HEALTH RECORD SYSTEMS, AND PROVIDE ADEQUATE SENSITIVITY AND SPECIFICITY. NOTHING IN THE PRECEDING SENTENCE PROHIBITS THE USE OF PROPRIETARY MEASURES IN THE QPP.

(II) ADVISORY COMMITTEE.—

(A) IN GENERAL.—NOT LATER THAN 1 YEAR AFTER THE DATE OF THE ENACTMENT OF THIS SECTION, THE SECRETARY SHALL ESTABLISH AN ADVISORY COMMITTEE TO BE KNOWN AS THE 'NATIONAL OUTPATIENT THERAPY QUALITY ADVISORY COMMITTEE (IN THIS SUBSECTION REFERRED TO AS THE 'COMMITTEE') FOR PURPOSES OF CARRYING OUT THE DUTIES SPECIFIED IN SUBPARAGRAPH (B).

(B) DUTIES.—THE DUTIES OF THE COMMITTEE ARE THE FOLLOWING:

(I) TO PROVIDE TO THE SECRETARY RECOMMENDATIONS WITH RESPECT TO REQUIREMENTS THAT MAY BE DETERMINED APPROPRIATE BY THE SECRETARY PURSUANT TO PARAGRAPH (3(I)), INCLUDING ANY RECOMMENDATIONS ON PROPOSED REGULATIONS RELATED TO REFORMS FOR THE THREE INDIVIDUAL THERAPY DISCIPLINES. IN DEVELOPING SUCH RECOMMENDATIONS, THE COMMITTEE SHALL PRIORITIZE—

(I) FORMULATION OF RECOMMENDATIONS TO ENSURE AGREEMENTS WITH EXTERNAL CONTRACTORS TO DEVELOP MEASURES THAT ENSURE ALL APPLICABLE PROVIDERS ARE REPRESENTED IN THE TRIGGER/CONFIRMING CODES FOR THE MEASURE.

(II) DEVELOPMENT OF OPTIONS FOR THE ABILITY OF FACILITY-BASED REHABILITATION THERAPISTS TO PARTICIPATE IN THE QUALITY PAYMENT PROGRAM.

(III) IDENTIFICATION OF BARRIERS AND DEVELOPMENT OF RECOMMENDATIONS TO FACILITATE PARTICIPATION OF THERAPISTS IN THE QUALITY PAYMENT PROGRAM.

IV. CONSULT WITH MEASURE DEVELOPERS TO ENCOURAGE DEVELOPMENT OF MEASURES THAT REFLECT THE IMPACT OF REHABILITATION ON THE COST AND QUALITY OF CARE.

V. FORMULATION OF OPTIONS FOR THERAPY PROVIDERS TO BE EXEMPTED FROM THE CURRENT COST MEASURE REQUIREMENT UNDER THE QUALITY PAYMENT PROGRAM.

(C) COMPOSITION.—THE COMMITTEE SHALL BE COMPOSED OF NOT FEWER THAN 9 INDIVIDUALS SELECTED BY THE SECRETARY. SUCH INDIVIDUALS SHALL NOT BE OFFICERS OR EMPLOYEES OF THE FEDERAL GOVERNMENT AND SHALL INCLUDE—

(I) OCCUPATIONAL THERAPISTS NOMINATED BY THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION;

(II) PHYSICAL THERAPISTS NOMINATED BY THE AMERICAN PHYSICAL THERAPY ASSOCIATION;

(III) SPEECH-LANGUAGE PATHOLOGISTS NOMINATED BY THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION;

(IV) OTHER INDIVIDUALS DETERMINED APPROPRIATE BY THE SECRETARY, INCLUDING PATIENTS REPRESENTING EACH OF THE AFFECTED COMMUNITIES.

(D) MEETINGS.—THE COMMITTEE SHALL CONVENE NOT LESS THAN THREE TIMES EACH YEAR.

(III) REGULATIONS.— NOT LATER THAN 2 YEARS AFTER THE DATE OF THE ENACTMENT OF THIS SUBSECTION, THE SECRETARY PUBLISH PROPOSED REGULATIONS BASED ON THE RECOMMENDATION OF THE COMMITTEE.

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives

Energy and Commerce Subcommittee on Health

Re: Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms.

May 19, 2026

Division of Legislative Counsel
202-789-7426

STATEMENT
of the
American Medical Association
to the
U.S. House of Representatives
Energy and Commerce Subcommittee on Health

Re: Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms.

May 19, 2026

The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record for the hearing entitled, "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms." The AMA commends the Subcommittee for its continued attention to the affordability and access challenges facing American patients and the physicians who care for them and stands ready to work with Congress to enact reforms that restore stability and affordability to the Medicare physician payment system.

The AMA appeared before this Subcommittee on March 18 to discuss the affordability and access challenges facing patients and physicians in the current health care marketplace. This statement builds on that testimony by focusing on the central affordability problem at the heart of the Medicare program: the Medicare Physician Fee Schedule (MPFS) no longer reflects the cost of providing care. The dysfunction of that payment system is making it increasingly unaffordable for physicians to keep their practices open, which directly impacts patient access to affordable care.

First, affordability for patients and affordability for physician practices are two sides of the same problem. When physician practices cannot cover the cost of care, they close, consolidate, or limit Medicare participation. Patients are then pushed into higher-cost settings, where they face larger facility fees and higher cost-sharing. The federal government and beneficiaries together pay more for the same care.

Second, the affordability problem facing physician practices is structural. Medicare physician payment has declined 33 percent in real terms since 2001 when adjusted for the cost of running a medical practice. This is largely because physicians are the only type of Medicare provider whose payment formula does not increase with inflation. Meanwhile, practice costs, including staff wages, medical supplies, technology, compliance, and professional liability insurance, have also continued to rise throughout this period.

Third, the reforms outlined below are not aspirational. Each is reflected in active legislation with bipartisan support or in formal AMA policy endorsed by every state medical society.

The Affordability Crisis in Medicare Physician Payment

Patients face rising health care costs while physician practices face declining reimbursement. These two pressures are connected. The structure of the MPFS, which has not received a permanent inflationary update in more than two decades, is the link.

Physicians and other qualified health care providers remain the only Medicare provider type that does not receive an automatic annual inflationary update. The result is a 33 percent real decline in Medicare physician payment since 2001. As hospital outpatient services are updated for inflation every year and

physician office services are not, there is a widening differential in site-of-service payment rates that makes independent practice increasingly unsustainable for physicians.

According to data from the Centers for Medicare & Medicaid Services (CMS), Medicare physician payment rates have increased by approximately 10 percent over the past 25 years, an average annual increase of about 0.4 percent. Over the same period, the Medicare Economic Index (MEI), which measures inflation in physician practice costs such as office rent, staff wages, medical supplies, and professional liability insurance, rose approximately 63 percent, or about 2.0 percent annually.

Medicare physician services remain the most stable component of Medicare Part B spending. Between 2015 and 2025, per-enrollee spending under the MPFS grew 19 percent, or about 1.7 percent annually. Meanwhile, the remainder of Medicare Part B fee-for-service spending, which includes outpatient hospital services, durable medical equipment, Part B drugs and other services, grew 86 percent over the same period, or 6.4 percent annually. Despite this, increasingly more Medicare Part B services are being directed away from the physician office setting. The share of Part B fee-for-service spending attributable to physician services fell from 38 percent in 2015 to 28 percent in 2025.

Why is this? When physician payment stagnates while practice costs and administrative demands rise, the practical effect is to make community-based physician care progressively less viable. Small, rural, and independent practices are particularly vulnerable. Practices are forced to consolidate with more expensive care settings, limit the number of Medicare patients they can treat, or close their doors altogether. As a result, access to care suffers. Patients who could once receive care close to home are pushed into higher-cost settings, and federal health programs incur higher per-encounter spending. In other words, the system spends more to deliver less.

Four reforms, taken together, would stabilize Medicare physician payment and begin to restore affordability for patients and physicians alike.

Reforms to Stabilize Medicare Physician Payment

A permanent inflationary update tied to the Medicare Economic Index

As described above, the absence of a permanent inflationary update is the structural failure at the root of the affordability crisis facing physician practices. Preventing the 33 percent real-dollar gap from widening further requires that future updates keep pace with the cost of providing care.

The AMA strongly supports H.R. 6160, the Strengthening Medicare for Patients and Providers Act, which would provide a permanent annual update tied to the MEI. The previous bill in the 118th Congress, H.R. 2474, secured more than 170 bipartisan cosponsors. We urge the Subcommittee to advance H.R. 6160 in the 119th Congress.

Last year, in its June 2025 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended a major overhaul to how Medicare updates physician payments, calling for a long-term, inflation-adjusted approach that better reflects the cost of providing care. MedPAC recommends replacing the updates under current law with a permanent, inflation-based formula tied to the MEI, such as MEI minus one percentage point.

A permanent MEI-based update is necessary but not sufficient alone. Without the budget neutrality reforms described below, annual statutory cuts will continue to claw back payment dollars even after an MEI update is enacted. The two reforms must be paired.

Budget Neutrality Reform

Under current law, any change CMS makes to the Medicare Physician Fee Schedule, whether adding a new code, revaluing an existing service, or adjusting payment for a procedure, must be "budget neutral,"

meaning it cannot increase total Medicare physician spending. CMS implements this requirement by adjusting the conversion factor, the dollar multiplier that determines payment for every service under the fee schedule.

The mechanics are projection-based. CMS estimates how much utilization the change will generate in the following year and then cuts the conversion factor by enough to offset that projected new spending. The problem is that these utilization estimates are projections, not observed data. When projections turn out to be too high, the offsetting cut is too large. And because current law contains no mechanism to reconcile projected utilization with actual utilization after the fact, the erroneous cut becomes permanent.

The 2024 implementation of code G2211 illustrates how this plays out in practice. G2211 is an add-on code CMS added to the fee schedule that year to better capture the complexity of primary care and certain longitudinal care services. To offset the projected utilization of G2211, CMS imposed an approximate 2.5 percent across-the-board cut to the conversion factor. But actual 2024 G2211 claims came in nearly one billion dollars below CMS' projections, leaving physician practices with a permanent cut.

The AMA strongly supports H.R. 8163, the Provider Reimbursement Stability Act of 2025, bipartisan legislation introduced by Representatives Greg Murphy, MD (R-NC) and Tom Suozzi (D-NY). The bill includes four targeted, commonsense, complementary reforms that would help to address structural issues with the current budget neutrality process.

First, H.R. 8163 would require CMS to prospectively correct the MPFS conversion factor if there has been a utilization misestimate for a new unbundled code. This would be done by requiring CMS to compare the claims data for a newly unbundled code in the first year of implementation with the estimate that was done. If the estimate was wrong, CMS is required to readjust the conversion factor for the following year. This ensures that budget neutrality payment adjustments are accurate.

Second, the dollar threshold that triggers budget neutrality adjustments has remained unchanged at $20 million since it was first passed back in 1992. H.R. 8163 updates the threshold for inflation to $54.3 million beginning in 2027 and indexes it every five years to the MEI.

Third, H.R. 8163 requires CMS to update all categories of direct cost inputs (clinical staff wages, medical supply prices, and equipment prices) simultaneously and at least once every five years, in consultation with physician specialty societies. In the past, CMS took decades to review direct cost inputs; thus, the data utilized was years out of date. The decision not to review all three direct cost inputs concurrently and in a timely fashion has caused large and disruptive redistributions whenever updates eventually occur. This section of the legislation sets up a more sensible process for reviewing direct cost inputs to ensure greater stability within this portion of the MPFS.

Fourth, H.R. 8163 caps year-over-year variance in the conversion factor at 2.5 percent, with certain exclusions built in for Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) adjustments and future MEI updates. This guardrail prevents the kind of destabilizing swings that have characterized recent rulemakings.

Portions of the previous bill, H.R. 6371, passed the House Energy and Commerce Committee in the 118th Congress. H.R. 8163 builds on that bipartisan foundation. We thank Representatives Murphy (R-NC) and Suozzi (D-NY) for their leadership and acknowledge Representatives Joyce, MD (R-PA), Onder, MD (R-MO), Miller-Meeks, MD (R-IA), Schneider (D-IL), Panetta (D-CA), Schrier, MD (D-WA), and Kelly (D-IL) for their support of the bill.

Replace MIPS with the Data-Driven Performance Payment System

After nearly a decade of implementation, MIPS is failing to improve quality of care and has become a significant source of financial and administrative strain on practices, a burden that has disproportionately fallen on small, rural, and safety-net practices that serve Medicare's most vulnerable beneficiaries.

Complying with the program is expensive and burdensome without producing useful information about quality. A *Journal of the American Medical Association (JAMA)* Health Forum study found that MIPS compliance costs approximately $12,800 per physician per year and requires 202 hours of physician and staff time. Another *JAMA* study found that MIPS scores are approximately as effective as chance at distinguishing high-quality from low-quality performance.

As a result, MIPS is disproportionately penalizing small, rural, and independent practices that do not have the same resources as large practices and health systems to comply with the program's expensive and burdensome reporting requirements. In 2023, nearly 50 percent of solo eligible clinicians received a MIPS penalty, compared with fewer than 14 percent of eligible clinicians overall. Twenty-nine percent of small practices and 18 percent of rural practices were penalized. These same practices are also most likely to treat sicker, lower-income, and more medically complex patient populations and as a result receive lower MIPS scores.

Under current law, the penalties can be a cut of up to 9 percent on every service a practice bills to Medicare for an entire year. No other Medicare provider faces cuts this steep as part of a quality improvement program, and the penalties are hitting small, rural, and safety-net practices that have fewer resources to comply with the program's burdensome reporting requirements, leaving them with even fewer resources to remain financially viable and serve their communities.

Ten years on, the program is also failing to provide physicians with the data they need to improve care and manage costs. Despite statutory obligations, CMS is still not sharing actionable performance data with physicians in a timely manner. Physicians currently receive a single feedback report for a given performance year up to 18 months after services were rendered, long after they can make meaningful adjustments.

The AMA strongly supports H.R. 8622, the Medicare Physician Data-driven Performance Payment System Act of 2026, introduced by Representatives Mariannette Miller-Meeks, MD (R-IA) and Herb Conaway, MD (D-NJ). The bill establishes the Data-Driven Performance Payment System (DPPS), which has been endorsed by the AMA, every state medical society, and more than 100 national specialty societies. DPPS includes four core reforms which are designed to address the shortcomings of MIPS.

<u>End the tournament-style penalty structure</u>

First, DPPS replaces the existing payment adjustment to base pay with one tied to a portion of the physician's annual inflation update. Eligible clinicians who score above the performance threshold receive up to 1.25 times their annual update; those at the threshold receive their full update; those that report data but score below the threshold lose one quarter of their update; and those that do not report data lose one-half of their update. This structure aligns the program with how other Medicare quality programs, including the Hospital Inpatient Quality Reporting Program, approach payment adjustments.

<u>Stabilize the performance threshold</u>

Second, the bill freezes the MIPS performance threshold at 75 points for 2028 through 2033, providing an important, temporary period of stability as the other changes are rolled out. Alongside the freeze, the legislation directs the Government Accountability Office , in consultation with national medical specialty societies, to submit recommendations to Congress and the Secretary by December 31, 2029, on an

alternative threshold methodology. This approach ensures that any future threshold is grounded in reliable data and clinical relevance rather than the statistical benchmarking that currently disadvantages certain specialties and practice types.

Require timely feedback from CMS

Third, the bill would require CMS to share timely performance data with physicians. Physicians who do not receive at least three quarterly performance feedback reports during the performance period would be exempt from any DPPS penalty applied to their payment updates for the relevant performance period. With access to timely quarterly reports detailing attributed cost measures, assigned patients, and costs outside the practice, physicians will be more equipped to make real-time adjustments that improve care and reduce avoidable Medicare spending.

Reinvest penalty funds in under-resourced practices

Finally, the bill would require that any penalty funds not paid out as bonuses be directed into an improvement fund for small, rural, safety net, and other types of under-resourced practices. These funds can be used to invest in new technologies and innovative care solutions that advance patient care and outcomes, including reimbursement for enhanced care management services, the purchasing of certified electronic health record technology, and participation in value-based care models. This reinvestment mechanism ensures that resources generated by the program flow back to the practices and patients that need them most.

Importantly, DPPS does not require any new funding. It simply restructures an already budget neutral program to help it meet the statutory intent of more meaningfully measuring quality of care and improving patient outcomes.

Stabilize and Expand Alternative Payment Models

APMs are intended to support physician efforts to redesign the delivery of patient care in ways that simultaneously improve health care outcomes and reduce Medicare spending. That promise has not been realized. Fortunately, there are several interventions Congress can undertake to both stabilize and expand the pathway to APMs, which is especially important for specialty, rural, and other types of practices that have had limited opportunities to participate in APMs to date.

Extending the MACRA APM Incentives

The Consolidated Appropriations Act of 2026 restored the 3.1 percent APM incentive payment and lowered the qualifying threshold for the 2026 performance year and 2028 payment year. However, these changes are in effect for twelve months only.

The AMA urges Congress to extend the current 3.1 percent bonus and permanently maintain the qualifying threshold at 50 percent of payments, which demonstrates that a majority of a participant's Medicare or total payments are flowing through the APM. If the qualifying threshold reverts to 75 percent of payments or 50 percent of patients mandated under the current statute, virtually no physician practices would qualify for the APM bonus. Without both policies, the APM track of MACRA collapses.

It is also important that Congress continue these policies to ensure that incentives remain for physicians that, to this point, have limited or no opportunities to join clinically relevant APMs, particularly physicians in rural practices or specialties. Of the limited specialty models that do exist, most are based around conditions or episodes of care, which inherently means they are applicable to a smaller subset of patients or payments and not a physician's entire patient population, but does not mean these professionals are any less dedicated to meaningfully improving outcomes for those patients. Other practices, including rural, small, and independent practices, often have fewer resources and leaner profit margins and are less able to take on substantial financial risk and/or afford the upfront investments it

takes to start up and be successful in an APM. Accordingly, the AMA would also support Secretary discretion to create a separate threshold for certain types of practices that face additional barriers to APMs or those in episode or condition-focused models that may struggle to meet the same payment or patient thresholds as primary care centric APMs.

Require CMMI to Test Proven Physician-Designed Payment Models that Address Current Participation Gaps

The CMS Innovation Center has, thus far, been unwilling to test models designed by physicians and medical societies, even after the Physician-Focused Payment Model Technical Advisory Committee (PTAC), created by Congress under MACRA, demonstrated that physicians can develop sound payment models. PTAC endorsed numerous proposals; yet so far the Center for Medicare and Medicaid Innovation (CMMI) has implemented exactly zero of them.

The AMA proposes that Congress create the IMPACT Program (Implementing Physician-Led Ambulatory Care Transformation), funded by carving $1 billion from CMMI's existing $10 billion appropriation, with no new federal spending required. Key features of IMPACT include:

- Grants would be available to physicians, physician practices, and medical societies, which currently lack access to capital to test innovative approaches.
- CMMI would be required to accept applications at least twice annually, decide within three months of receipt, and begin funding within three months of approval.
- Grant awards would run a minimum of five years. CMMI would be required to continue funding beyond five years if an independent evaluation showed the project reduced Medicare spending while maintaining quality of patient care, or demonstrated improved patient outcomes or expanded access without increased spending.
- CMMI would be required to solicit input from medical societies (other than the applicant society) on each application and publicly respond to that input in its funding decisions.

The IMPACT design corrects a known structural flaw in CMMI's earlier Health Care Innovation Awards (HCIA) program. The first round of HCIA awards in 2012 distributed more than $826 million to 107 projects, and the second round in 2014 distributed $322 million to 39 additional projects. Eighteen first-round ambulatory care projects achieved significant reductions in total cost of care, and several second-round projects also achieved significant savings. But CMMI created no mechanism to sustain successful projects after grant funding lapsed, and the agency declined to implement PTAC-endorsed proposals to convert HCIA successes into permanent payment models. IMPACT would help close that gap by making continuation funding mandatory rather than discretionary. If an independent evaluation finds that a project reduced Medicare spending without quality loss, or improved patient outcomes without increased spending, CMMI must extend funding beyond the initial five-year term and expand the number of physicians who can participate.

In addition to this pipeline for private-sector-developed APMs, CMMI should also make a concerted effort to develop models that are specifically designed to close current participation gaps for rural, specialty, and other types of practices that so far have lacked clinically relevant CMMI models to join.

CMMI also continues to design models in a vacuum with little to no clinician input during the development process until the model is announced. It is unsound public policy to permit the government to develop clinically relevant care delivery models without input from the physicians treating those patients. As a result, it should come as no surprise that the majority of CMMI models to date have not yielded the desired results. Physician input is critical early on and throughout the model development process. The AMA would be a willing partner to bring physicians to the table for these types of discussions.

Restrict mandatory physician participation in CMMI models

There is no shortage of physicians who want to be part of well-designed payment models that will enable them to deliver better care. The reason many physicians have not participated in alternative payment models to date is not because the physicians are unwilling to accept different methods of payment, but because there is either not a clinically relevant model to begin with, as noted above, or the models that are available have not provided the support physicians need to improve the delivery of care to their patients. Furthermore, the models that do exist require the physician to accept an unsustainable level of financial risk. This also explains why participation from practices with fewer resources and profit margins, such as small, independent, and rural practices, has lagged behind.

As of late, CMS has attempted to get around these design flaws by simply mandating participation. However, many of these models are designed with blunt cost cutting, not optimizing patient care, as the primary objective, featuring mandatory discounts or target prices with a percentage reduction, with seemingly no logical basis grounded in clinical best practice, but rather an artificial savings target that CMS has set out to achieve. The problem with this approach is, even if practices are able to successfully achieve one-time savings relative to current spending, without changing the underlying paradigm of how care is being delivered, this temporary success will be short-lived.

Instead of designing models with short-sighted cost savings as the primary objective, CMMI needs to be leveraging APMs as they are intended, to support physician efforts to redesign care delivery in ways that achieve the best clinical outcomes for each patient while avoiding unnecessary tests, services, and complications. This is the only truly sustainable way to yield long-term savings and, most importantly, actually advance patient quality of care and clinical outcomes. If a Medicare payment and care delivery program is designed with the patient at its core, with adequate support for improvements in care delivery coupled with appropriate levels of financial risk and accountability based on what is within the physician's ability to control, there will be no need to mandate physician participation. There is also clear evidence that voluntary payment models can achieve greater savings than mandatory payment models.

Mandatory payment models that include financial risk have the potential to harm patients, as well as physicians, and should have no place in medicine. At a minimum, the AMA recommends that Congress prohibit CMMI from mandating physician participation in any model that has not first been tested voluntarily and limit mandatory implementation to cases in which voluntary testing failed because of selective participation rather than design weaknesses in the model itself.

Consolidation as a Symptom of Payment Failure

The four reforms above address the structural cause of the affordability problem. They also begin to address its most visible symptom: the consolidation of American health care. The U.S. health care market is becoming increasingly concentrated across every layer. In 2024, 97 percent of commercial health insurance markets in metropolitan statistical areas were highly concentrated. Ninety-nine percent of hospital MSA markets were highly concentrated in 2021, and hospital mergers in concentrated markets have raised prices by as much as 65 percent. Physician practice ownership has shifted accordingly: the share of physicians in private practice fell from 60.1 percent in 2012 to 42.2 percent in 2024, an 18-point decline in twelve years.

Site-of-service differentials accelerate the cycle

Medicare currently pays significantly higher rates for many identical services when they are delivered in a hospital outpatient department than in a physician's office. This differential is not tied to clinical differences in the service itself; it reflects only the setting. The differential creates a powerful financial incentive for hospitals to acquire physician practices and rebill the same services at higher facility rates, with corresponding increases in patient cost-sharing. Simply lowering payments down to the insufficient Medicare Physician Fee Schedule level, however, is not the answer to this complicated problem. Instead,

the AMA supports moving toward more consistent payment across sites of care for clinically comparable services, provided such reforms do not further reduce already-strained physician payment or diminish overall Medicare spending on physician services.

Physician-owned hospitals as competitive counterweight

Physician-owned hospitals can introduce competitive pressure that improves quality and lowers costs in highly consolidated hospital markets. The AMA supports H.R. 4002, the Patient Access to Higher Quality Health Care Act of 2025, which would repeal Affordable Care Act restrictions on the Stark Law whole hospital exception.

Vertical integration

The AMA urges continued federal data collection on the cost and quality effects of vertical integration across insurers, hospitals, and physician practices. The 2023 Department of Justice and Federal Trade Commission Merger Guidelines provide a framework for evaluating vertical mergers, and we encourage aggressive enforcement where consolidation may substantially lessen competition for the purchase of physician services.

Conclusion

Together, the four reforms in this statement would help to restore stability to Medicare physician payment and ease administrative pressures on federal health programs, reversing some of the core drivers of health care consolidation, and preserving patient access to affordable, community-based care.

1. H.R. 6160, the Strengthening Medicare for Patients and Providers Act, would provide the permanent inflationary update tied to the MEI that physicians have lacked for a quarter century, closing the gap between rising practice costs and stagnant Medicare physician payment, and help to address the growing gap between services delivered in a physician office, versus more expensive inpatient or outpatient settings.

2. H.R. 8163, the Provider Reimbursement Stability Act, would help to protect that update from being eroded by the well-intentioned, but outdated, budget neutrality mechanism and ensure that flawed utilization estimates no longer produce permanent cuts to the conversion factor.

3. H.R. 8622, the Medicare Physician Data-driven Performance Payment System Act of 2026, would replace MIPS with a fair, stable, and transparent performance program that would finally end the era of penalizing practices that see sicker, more vulnerable patients while giving the majority of incentive money to well-resourced systems, all in a way that is designed to align with how other Medicare quality programs already operate.

4. Permanent stabilization of the Alternative Payment Model incentive payment and qualifying threshold, paired with the new IMPACT program, would help to preserve the APM pathway for physicians who have already invested in it, and give those that have not yet had the same level of opportunity via a direct channel through CMMI to test and expand innovative care models designed with input from physicians and other clinicians on the front lines of patient care.

Each reform is built on formal AMA policy endorsed by every state medical society and more than 100 national specialty societies. The AMA stands ready to work with the Subcommittee, with both Republican and Democratic leadership, and with the broader Federation of Medicine to advance these reforms. The AMA thanks the Subcommittee for its consideration of these reforms and for its continued attention to the affordability and access challenges facing American patients and the physicians who care for them.

U.S. House Committee on Energy and Commerce, Health Subcommittee

Hearing:
Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms

May 20, 2026

Statement for the Record from the American Academy of Dermatology Association

Chairman Griffith and Ranking Member DeGette, on behalf of the more than 18,000 U.S. members of the American Academy of Dermatology Association (AADA), we thank you for the opportunity to submit a statement for the record regarding your hearing, *Examining the Medicare Physician Fee Schedule (MPFS), Medicare Access and CHIP Reauthorization Act (MACRA), and Opportunities for Payment Reforms*.

A board-certified dermatologist has extensive training, which allows them to accurately diagnose and properly treat more than 3,000 diseases of the skin, hair, and nails. Declining Medicare physician payment and administrative burdens amplify physician burnout and threaten patient access to care. Every closed practice, every second of delayed care, every unfilled job in a practice, all hampers coordination and threatens the viability of Medicare. Unfortunately, after more than twenty years of cuts to Medicare physician payment, these delays, closures, and unfilled roles are far too common.

To protect access and ensure affordability for patients while protecting physician practices from further consolidation, Congress must take action to advance Medicare physician payment reform by establishing a positive annual inflation adjustment and increasing the budget neutrality threshold.

We would like to extend our gratitude to the co-chairs of the House GOP and Democratic Doctors Caucuses, Reps. John Joyce, MD, FAAD (R-PA), Greg Murphy, MD (R-NC), and Kim Schrier, MD (D-WA) for their leadership in proposing bipartisan solutions to modernize MACRA. We are encouraged by the legislation they are developing to strengthen and stabilize the Medicare physician payment system. This comprehensive, draft legislation would modernize MACRA with a three-pronged approach to:

1. Provide a permanent inflationary update at the Medicare Economic Index (MEI) minus 1%;
2. Reform budget neutrality rules and raising the outdated threshold, utilizing the policies from H.R. 8163, the Provider Reimbursement Stability Act; and
3. Overhaul the Merit-based Incentive Payment System, better known as MIPS, to reduce physician burdens and provide greater input on quality metrics.

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The permanent inflationary update policy in this draft legislation is drawn from the recommendation by the Medicare Payment Advisory Commission (MedPAC) to tie Medicare physician payment to the MEI minus 1 percentage point. In making this recommendation, MedPAC has noted their concerns about whether beneficiaries will continue to have adequate access to care in the coming years as growth in physician practice operating costs is expected to exceed growth in Medicare payment rates by a greater amount than it did in the prior two decades. This larger gap could create incentives for physicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program.

The failure of the MPFS to keep up with inflation is the greatest threat to access to care in physician offices. Stabilizing the MPFS is critical to fortify independent medical practice, combat consolidation and maintain access for patients. While physicians have long advocated for inflation updates tied to full MEI, the policy in this draft bipartisan framework would be a vital building block towards long-term, sustainable reform of predictable annual inflationary adjustments. We look forward to continuing our collaboration with Reps. Joyce, Schrier, and Murphy, as well as the entire physician community, to refine and advance this comprehensive effort.

Stabilizing Medicare Physician Payment to Ensure Patient Access to Affordable Care

Stable and predictable Medicare reimbursement will help lead to greater access for patients and increase the bandwidth of health professionals to coordinate care. Since 2001, the cost of operating a medical practice has increased 59%. During this time, Medicare hospital and nursing facility updates resulted in a roughly 70% increase in payments to these entities, significantly outpacing physician reimbursement. Adjusted for inflation in practice costs, Medicare physician reimbursement declined 33% from 2001 to 2025. This out-of-balance payment structure disproportionately threatens the viability of medical practices, especially smaller, independent, physician-owned practices, as well as those serving low-income or historically marginalized patients. Dermatologists are seeing the real effect of cuts. In the past 8 years, private insurance patients for dermatologists have increased by 21% while Medicare patients are down 27%.

Physicians rely on reimbursement to cover a multitude of practice expenses. These expenses include office overhead, medical supplies, staff salaries, benefits, governmental regulatory compliance costs, and expenses associated with insurance mandates. Inflation and practice expenses keep rising and reimbursement continues to decline.

The current Medicare physician payment system has led to increased consolidation and hospital ownership of physician practices resulting in higher national health care expenditures and reduced competition to the health care system. As physician offices close or become consolidated within larger health systems with narrow networks to specialists and subspecialists. This results in reduced accessibility to affordable, high-quality dermatologic care.

Dermatologists have had to reevaluate how to operate their practices. Many have considered closing their doors, changing their payer mix, leaving their communities, or simply retiring early. The inability to provide inflationary pay raises to practice employees is contributing to the current health care workforce

crisis in which we are seeing increasing burnout rates and a mass exodus of our clinical, administrative, and clerical staff into other industries.

Fewer physicians in our communities means longer waiting times for patients to receive care. According to the Health Resources and Services Administration, currently, dermatology is only able to meet approximately 37.1% of patient demand in non-metro areas. When those patients do receive care, their only option may be non-physician providers of care with less training, or more expensive care in suboptimal settings including emergency departments and hospital-based practices. Medicare patients will suffer in the end with delayed and second-rate care at a higher cost. Declining reimbursement and increasing administrative burdens will exacerbate this shortage of physicians when offices close their doors.

To make matters worse, in the CY 2026 MPFS, CMS finalized a proposal to apply a 2.5 percent "efficiency adjustment" policy, which is not supported by valid data, is inconsistent with the Medicare statute, undermines the relativity of resource-based relative value scale, and most importantly, risks harming patient care. CMS has not explained the rationale for selecting 2.5 percent for the efficiency adjustment beyond citing productivity adjustments in the MEI, which has no meaningful relationship to physician work. Applying an economy-wide productivity factor to physician services is arbitrary and ignores the realities of clinical care. There is no evidence that dermatologists, or physicians in general, are performing procedures more efficiently today than in the past.

Declining Medicare physician payment ultimately means fewer options for patients to choose their own physician and health insurance that best meets their needs. This poses significant access and affordability challenges for patients. The MPFS today is unsustainable for physician practices, which is why Congress must enact reforms to modernize the system.

Further Bipartisan Reforms to the MPFS

In addition to the bipartisan, comprehensive MACRA reform being developed by Reps. Joyce, Schrier, and Murphy, the AADA supports the following bipartisan proposals that will improve the sustainability of the Medicare program for physicians and the patients they serve:

- H.R. 6160, the Strengthening Medicare for Patients and Providers Act: Introduced by Reps. Raul Ruiz, MD (D-CA) and Gus Bilirakis (R-FL) to provide for an inflationary update under the Medicare physician fee schedule tied to MEI beginning in 2026
- H.R. 8163, the Provider Reimbursement Stability Act of 2026: Introduced by Reps. Greg Murphy, MD (R-NC) and Tom Suozzi (D-NY) to raise the outdated budget neutrality threshold in the MPFS, which has not been updated since 1992, tie future updates to MEI every five years, and allow CMS to make corrections when they overestimate utilization
- H.R. 7520, the Efficiency Adjustment Delay Act: Introduced by Reps. Ron Estes (R-KS) and Tom Suozzi (D-NY) to delay the flawed "efficiency adjustment" finalized in the Calendar Year 2026 MPFS until 2030
- H.R. 8622, the Medicare Physician Data-driven Performance Payment System Act: Introduced by Reps. Mariannette Miller-Meeks, MD (R-IA) and Herb Conaway, MD (D-NJ) to eliminate MIPS win-lose "tournament style" penalties and instead would link physicians' MIPS performance to a portion of their annual payment updates

On behalf of the AADA, thank you for your leadership and help ensuring that Medicare meets the needs of Americans. The AADA is committed to excellence in the medical and surgical treatment of skin diseases; advocating for high standards of clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease. The AADA welcomes the opportunity to continue working with Congress to identify opportunities to maintain patient access to affordable care and improve outcomes. Together, we can make a positive difference for patients across the nation.

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Association of American Medical Colleges
Statement for the Record
before the
House Energy and Commerce Health Subcommittee
"Examining the Medicare Physician Fee Schedule,
MACRA, and Opportunities for Payment Reforms"
May 20, 2026

The AAMC (Association of American Medical Colleges)[1] appreciates the opportunity to submit this statement for the record regarding the "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms" hearing on May 20, 2026. The AAMC recognizes the ongoing challenges related to the Medicare and CHIP Reauthorization Act (MACRA, P.L. 114-10), and we welcome the chance to share the perspective of academic medicine and to work with you as you discuss potential improvements that will ultimately make care more affordable.

Through their mission of providing the highest quality patient care, teaching physicians who practice at academic health systems and at teaching hospitals provide care in what are among the largest physician group practices in the country, often described as "faculty practice plans," because many of these physicians teach and supervise medical residents and students as part of their daily work. These faculty practice plans are typically organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care. Often, care is multidisciplinary and team-based. These faculty practices are frequently organized under a single tax identification number (TIN) that includes many specialties and subspecialties. Recent data shows that faculty practice plans range in size from a low of 315 individual national provider identifiers (NPIs) to a high of 5,692 NPIs, with a mean of 1,857 and a median of 1,479.[2] These practices support the educational development of residents and physicians who will become tomorrow's physicians.

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[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 163 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

[2] Data derived from The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient.

Teaching physicians are vital resources for their local and regional communities, providing a significant volume of primary care services and other critical services, including a large percentage of tertiary, quaternary, and specialty referral care in the community. Their patient base may span regions, states, and even the nation. They also treat a disproportionate share of patients for whom issues such as housing, nutrition, and transportation contribute significantly to additional health challenges, adding greater complexity to their care.

Faculty physician practices at AAMC member institutions continue to struggle under the implementation of MACRA, in particular, the frequent annual pay cuts that can occur. While Congress has mitigated some of these cuts, the uncertainty necessitates difficult decisions regarding staffing, patient care, and facility maintenance. We are pleased that the Subcommittee is discussing this pressing issue, and offer the following recommendations:

Pass the Provider Reimbursement Stability Act (H.R. 8163)
The AAMC strongly supports the Provider Reimbursement Stability Act (H.R. 8163) and urges Congress to pass it promptly. This legislation directly addresses several of the structural flaws that have allowed Medicare physician payment to deteriorate so dramatically. When adjusted for inflation, physician payments have fallen by approximately 33 percent since 2001, even as practice costs have continued to rise. Unlike every other Medicare provider, physicians receive no annual payment update tied to inflation, and budget neutrality requirements have compounded the problem by triggering across-the-board payment cuts year after year.

The bill addresses this through several complementary reforms. It would establish a two-year look-back period, allowing CMS to correct utilization misestimates for newly unbundled codes, which would close a longstanding gap where physicians are penalized indefinitely for actuarial errors that have nothing to do with the care they provide. It would also require the Centers for Medicare and Medicaid Services (CMS) to update direct cost inputs, including clinical staff wages, medical supply prices, and equipment costs, simultaneously and at least once every five years, preventing the large, disruptive redistributions that occur when outdated data is corrected all at once. It would also modernize the budget neutrality threshold, which has been frozen at $20 million since 1992, raising it to $54.3 million and indexing it to the Medicare Economic Index going forward. Finally, it would cap year-to-year swings in the conversion factor at 2.5 percent, introducing a degree of predictability that physician practices have long lacked.

The AAMC views this legislation as an important step toward a Medicare physician payment system that is stable, accurate, and reflective of the true costs of delivering care, and we continue to call for an annual inflationary update tied to the MEI as part of the broader reform agenda.

Strengthen and Sustain Advanced Alternative Payment Models (AAPMs)
The AAMC recommends that any reform or replacement of MIPS advance a quality program that meaningfully improves patient outcomes, supports value-based care, and reduces administrative burden. To that end, Congress should strengthen AAPMs, remove barriers to

participation, and make targeted improvements to MIPS to ensure fair measurement, appropriate risk adjustment, and less burdensome reporting.

Extend the Advanced APM Bonus
When Congress enacted MACRA, it recognized that transitioning from fee-for-service to value-based care requires upfront investment. Participating in an AAPM means bearing financial risk for the cost and quality of care, and clinicians must fund that transition themselves by investing in new care coordination infrastructure, staffing, technology, and practice redesign. A 5% bonus payment was designed to make that investment feasible and to signal that the government was a committed partner in the transition.

The bonus, however, has effectively expired, and without a meaningful financial incentive, clinicians face the costs and risks of AAPM participation with diminishing reward. This threatens to reverse real, hard-won progress: Accountable Care Organizations (ACOs) in the Shared Savings Program have generated $13.3 billion in gross savings for Medicare since 2012 and outperformed fee-for-service providers on 81% of quality measures.[3] Allowing participation to decline now would squander that investment. Congress should restore the bonus, such as through legislation like the Value in Health Care Act (H.R. 5013) from the 118th Congress, which would extend the AAPM 5 percent bonus for an additional 6 years.

Modify Thresholds to Achieve Qualifying Participants (QPs) Status in AAPMs
Compounding the issue of expiring bonuses, the thresholds clinicians must meet to qualify as AAPM participants are rising by statute to levels that are increasingly difficult to achieve. For specialists and rural providers in particular, who often cannot control the volume of patients attributed to an APM, these thresholds can be effectively unreachable. Congress has intervened three times to freeze them, implicitly acknowledging that the statutory trajectory is unworkable. We urge Congress to do so again and go further by granting CMS ongoing authority to set thresholds at levels calibrated to actually incentivize participation. Without that flexibility, the structural barriers to AAPM participation will continue to grow even if the bonus is restored, thus undermining the broader goal of a functional, sustainable alternative to fee-for-service.

Improve AAPM Participation Through Additional Policy Changes
While the bonus payments are very important, other factors affect an eligible clinician's decision about whether to participate in an AAPM. Providers consider whether the APM model aligns with care goals for their patient populations, especially whether the APM will enable them to be reimbursed for providing more coordinated, high-quality care than the current system. In addition, providers assess the overall financial opportunity of participation in the APM, including opportunity for sharing in savings, benchmarking methods that set reasonable financial targets

[3] US Department of Health and Human Services Office of the Inspector General, "Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality," Report (OEI-02-15-00450) (August 2017)

(including adequate risk adjustment), risk for outliers that could erase overall success, and time to implement care delivery changes in advance of taking on downside risk.

Additional Improvements Under Merit-based Incentive Payment System (MIPS)
The AAMC urges Congress to make additional changes to the Quality Payment Program (QPP) to make reporting and performance more meaningful for physicians and consumers and to encourage participation by increasing the pool of dollars available for payment incentives.

The MIPS incentives are budget-neutral so that any positive payment adjustments are funded by penalties. The only exception to budget neutrality has been a separate $500 million pool of funding established under MACRA for eligible clinicians who exceed the exceptional performance threshold. Under the MACRA statute, the $500 million funding allocation expired at the end of the 2022 performance year (2024 payment). Due to budget neutrality, this exceptional performance funding pool made up the bulk of positive payment adjustments received by clinicians. Even when this funding was available, the annual MIPS maximum payment adjustments were very low relative to the maximum percentages that were allowed under MACRA. Eligible clinicians who achieved the MIPS performance threshold had positive adjustments around zero, and those who achieved the exceptional performance threshold had positive adjustments below 2 percent.

To make reporting and performance more meaningful for physicians and patients, the AAMC recommends that cost measures used in MIPS be appropriately adjusted to account for the clinical and social complexity of patients. Differences in patient clinical complexity and health-related social needs can drive differences in average episode costs and performance on other measures. Without accurately accounting for the full complexity, the scores of physicians who treat vulnerable patients will be negatively and unfairly impacted, and their performance will not be adequately reflected in their MIPS score. Physicians at academic medical centers care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere.

It is critical that when measuring performance under MIPS, there is an accurate determination of the relationship between a patient and a clinician to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated given that patients often receive care from multiple clinicians across several facilities and teams within a single practice or facility. The attribution method should be clear and transparent to clinicians. We suggest that better data sources and analytic techniques should be explored in the future to support attribution.

The AAMC also recommends that Congress and CMS explore ways to reduce administrative burden under MIPS so that eligible clinicians can focus on providing high-quality care to their patients. One way to reduce burden for clinicians is to further ensure that AAPM participation is less burdensome than MIPS, as originally intended by Congress. We are concerned about the burden of recent CMS policies, such as the 2024 Quality Payment Program rulemaking

establishing MIPS as the baseline for all clinicians regardless of AAPM participation, and the future sunsetting of traditional MIPS reporting for MIPS Value Pathways (MVPs).[4, 5] We urge CMS to continue to make MVP reporting voluntary, given some of the conceptual challenges with the MVP reporting. As currently conceived, voluntary MVP reporting requires multi-specialty practices to arbitrarily subgroup clinicians to report on a limited set of measures that do not meaningfully represent specialty or team-based care delivery, while adding substantial burden on practices to redesign quality reporting. Practices should be given the opportunity to assess the advantages and disadvantages and select whichever option is most meaningful and least burdensome for participating in the QPP under MIPS.

Rein in Commercial Insurer Practices

While academic health systems dedicate extraordinary resources to patient care, education, and research, often under significant financial strain, the nation's largest commercial insurers continue to post billions in annual profits. The AAMC urges Congress to ensure that any action on health care costs directly confronts commercial insurer behavior, which imposes enormous and largely hidden burdens on hospitals, physicians, and patients alike.

The most visible manifestation of this is prior authorization. In 2023 alone, more than 50 million prior authorization requests were submitted to Medicare Advantage plans — and when those denials were appealed, 81.7% were fully or partially overturned, suggesting the vast majority of original denials were clinically unjustified. Some plans use automated algorithms to generate mass denials, knowing most will not be appealed. The human cost is real: patients face delays that worsen outcomes, and physicians and health systems must dedicate entire teams to fighting for care they have already determined is necessary. But prior authorization is only part of the picture. Delayed and retroactive payment denials, inadequate reimbursement rates, and network exclusions impose additional hidden costs — an AHA survey found more than $6.4 billion in delayed or denied claims system-wide. Meanwhile, rising premiums and the proliferation of high-deductible plans are pushing patients away from care altogether, driving up long-term costs when conditions worsen.

The AAMC supports legislative and regulatory reforms to address each of these issues and urges the Subcommittee to pursue a full examination of insurer practices and their role in driving health care unaffordability.

Conclusion

The AAMC appreciates the opportunity to offer our perspective, and we look forward to working with the Subcommittee as you work to improve the Medicare physician payment system. For further questions, please contact Len Marquez, AAMC senior director, government relations and legislative advocacy, at lmarquez@aamc.org, or Ally Perleoni, AAMC director, government relations, at aperleoni@aamc.org.

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[4] Community Letter to CMS on CEHRT Policies for Value-Based Care (April 2024).
[5] 90 FR 49266, at 49841 (Nov. 5, 2025).

Statement for the Record
From the Society of Gynecologic Oncology
For the House Committee on Energy and Commerce
Subcommittee on Health
Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reform
May 20, 2026

On behalf of the Society of Gynecologic Oncology (SGO), thank you for the opportunity to submit this statement for the record for the Energy and Commerce Subcommittee on Health's ("the Subcommittee") hearing examining the Medicare Physician Fee Schedule (MPFS) and the Medicare Access and CHIP Reauthorization Act (MACRA). We appreciate the Subcommittee's leadership in evaluating reforms to ensure that Medicare beneficiaries, including those with gynecologic cancers, continue to have access to high-quality physician services.

The SGO is the premier medical specialty society for healthcare professionals trained in the comprehensive management of gynecologic cancers. Our more than 2,700 members include physicians, advanced practice providers, nurses, and patient advocates who collaborate with the SGO's foundation, the Foundation for Women's Cancer, to increase awareness of gynecologic cancers and improve the care of those diagnosed with gynecologic cancers. Our mission focuses on supporting research, disseminating knowledge, raising the standards of practice in the prevention and treatment of gynecologic malignancies, and collaborating with other organizations dedicated to gynecologic cancers and related fields, all with the ultimate vision of eradicating gynecologic cancers.

Gynecologic oncologists play a multifaceted role in caring for their patients. They diagnose cancer, develop individualized treatment plans, perform highly complex surgeries, oversee chemotherapy and other treatments, manage complications, and monitor patients over time for recurrence and survivorship. Yet despite the increasing complexity of care and growing demands placed on physician practices, Medicare physician reimbursement has not kept pace with inflation or the costs of delivering this complex care. This instability threatens patient access, particularly in specialty fields such as gynecologic oncology where workforce shortages already exist in many communities.

Stabilizing Physician Payment Through Predictable Updates
The current physician payment system is unsustainable. Unlike every other major Medicare payment system, the MPFS lacks a permanent inflationary update tied to the actual costs of delivering care. The first statutory update to the conversion factor since 2019 occurred on January 1, 2026 when the differential conversion factors for clinicians in the Merit-Based Incentive Payment System (MIPS) and advanced Alternative Payment Models (APMs) were implemented.

SGO strongly urges Congress to establish a stable, predictable annual update to the MPFS conversion factor tied to the Medicare Economic Index (MEI). Physician practices face rising costs associated with clinical staffing, rent, medical supplies, equipment, malpractice insurance, and technology infrastructure. Without a meaningful annual inflationary adjustment, physicians have been expected to absorb these increases while continuing to meet growing administrative and reporting requirements. This issue is particularly acute in gynecologic oncology, where

practices care for medically complex Medicare beneficiaries requiring complex care. Congress has appropriately recognized inflationary pressures in hospitals, skilled nursing facilities, and other provider settings; physicians should not remain the only providers within Medicare without a reliable annual update.

Reforming Budget Neutrality to Preserve Access to Care

The current statutory budget neutrality requirement under the MPFS creates instability and pits physician specialties against one another. When new services are recognized or existing services are revalued, physicians experience across-the-board payment reductions if estimated expenditures exceed an outdated statutory threshold of $20 million, a figure that has never increased since the implementation of the MPFS. SGO urges Congress to raise the budget neutrality threshold and index it to inflation moving forward. The threshold no longer reflects the size and complexity of the Medicare program and results in unintended payment reductions that undermine the stability of physician practices.

Reject the Centers for Medicare & Medicaid Servies' (CMS) Efficiency Adjustment

As Congress examines physician payment reform, SGO urges policymakers to reject CMS' arbitrary assumptions that physician services become perpetually more efficient over time. In the Calendar Year 2026 MPFS, CMS implemented an "efficiency adjustment" based on the assumption that physicians performing procedures become increasingly efficient due to technological improvements and procedural repetition. On January 1, the physician work relative value units (RVUs) and intraservice time for procedures was reduced by 2.5%, and CMS plans to implement further reductions every three years. This is the first time CMS incorporated an ongoing productivity adjustment to physician work RVUs and intraservice time. Applying such an adjustment without evidence that efficiencies continue indefinitely is methodologically unsound and risks systematically undervaluing physician services. Physicians' procedural work cannot be presumed to become perpetually more efficient without eroding the accuracy and fairness of the fee schedule.

In gynecologic oncology, patient complexity frequently increases the time and expertise required to safely deliver care. Medicare beneficiaries commonly present with obesity, diabetes, hypertension, frailty, and other chronic conditions that complicate surgery and extend operative times. These realities often offset any efficiencies that may arise through physician experience. Moreover, gynecologic oncologists do far more than perform technical surgical procedures. They lead complex multidisciplinary operating room teams, oversee operative planning, ensure diagnostic information and documentation are available, coordinate clinical staff, make critical intraoperative decisions, and manage complications when they arise. This work extends well beyond the technical act of surgery itself.

Real-world workforce challenges further complicate assumptions about efficiency. Many practices have shortages of experienced operating room staff and support personnel. In many settings, physicians must spend additional time coordinating with less specialized teams, further undermining assumptions that procedures inevitably become faster over time.

Efficiency, if it exists, should not convert into an automatic payment reduction. Payment policy should be grounded in real-world data and clinical evidence, not unsupported assumptions that

physician work naturally becomes less resource-intensive each year. SGO urges the Subcommittee to ensure that changes in payment policy be grounded in empirical evidence.

MACRA and the Need for Meaningful Participation Pathways

Meaningful improvements to MACRA and Medicare's quality payment programs cannot occur without first stabilizing the physician payment system. Only then can we move closer to realizing the goals of value-based care.

We encourage Congress to work with CMS to support the development of specialty-relevant alternative payment models (APMs) that reflect diverse patient populations and less common cancers, including gynecologic malignancies. While MACRA was designed to encourage participation in APMs, specialty physicians often lack realistic opportunities to participate. For gynecologic oncologists, there are limited physician-focused payment models relevant to the care they provide, despite the highly coordinated and longitudinal nature of oncology care. These models should be developed in partnership with physician stakeholders and should avoid imposing excessive administrative burden or financial risk that discourages participation.

Similarly, reforms to the Merit-based Incentive Payment System (MIPS) must ensure physicians can meaningfully report measures relevant to their practice. While CMS is transitioning toward MIPS Value Pathways (MVPs), many specialties, including gynecologic oncology, still lack meaningful participation pathways. Providers should not be measured on metrics disconnected from the care they deliver. Congress should encourage the development of specialty-specific measures and support the meaningful use of electronic health records and interoperability tools that reduce, not increase, administrative burden.

Furthermore, Congress should ensure that CMS provides actionable feedback on their performance in MIPS or advanced APMs regularly. Physicians do not receive meaningful feedback in a timely manner to allow them to remedy any deficiencies. This is a longstanding problem that must be addressed. Additionally, employed physicians typically are disconnected from their performance in these programs and do not know if they are participating and if their participation is satisfactory. To improve patient outcomes, participants must understand how they are being measured and how their performance impacts the health of their patients.

Conclusion

SGO appreciates the Subcommittee's examination of the MPFS and MACRA and its commitment to preserving beneficiary access to care. Congress has an important opportunity to modernize physician payment by stabilizing annual updates, reforming budget neutrality, improving value-based payment pathways, reducing administrative burden, and ensuring physician work is valued accurately. We urge you to do so on a bipartisan basis.

Without meaningful reform, continued payment instability will further strain physician practices and threaten access to specialty care for Medicare beneficiaries, including patients diagnosed with gynecologic cancers. We stand ready to work with the Subcommittee to advance reforms that support high-quality, patient-centered care and ensure Medicare remains strong for future generations.

ENDOCRINE SOCIETY
Hormone Science to Health

Endocrine Society
Statement for the Record
House Energy & Commerce Committee
Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms
May 20, 2026

The Endocrine Society would like to thank Chairman Morgan Griffith (VA-09) and Ranking Member Frank Pallone (D-NJ) for conducting this important hearing on Medicare physician payment reform. Founded in 1916, the Endocrine Society represents approximately 18,000 physicians engaged in the treatment and research of endocrine disorders, such as diabetes, hypertension, infertility, obesity, osteoporosis, endocrine tumors/cancers (e.g., thyroid, adrenal, pancreatic, ovarian, pituitary) and thyroid disease. Our membership includes over 11,000 clinicians who are on the front lines in treating diabetes and obesity, which are two of the most common and costliest chronic illnesses in the United States. According to recent data, approximately 1 in 8 Americans is living with diabetes while more than 2 in 5 adults is living with obesity.[1][2]

We urge the Committee to pass bipartisan legislation that provides stability to physician reimbursement which would help address the challenges currently faced by endocrinologists. The endocrinology pipeline continues to face unprecedented challenges and there is a national shortage of endocrinologists. This shortage has had a significant impact on rural and underserved populations. Data show that approximately 78% of counties in the United States do not have a practicing endocrinologist.[3] This statistic is extremely alarming considering that endocrinologists treat Medicare beneficiaries with diabetes and obesity, which are two of the costliest chronic conditions in the United States. There is also the issue of physician compensation. Recent data show that aspiring physicians in medical school are less likely to choose primary care because of low compensation. The field of endocrinology faces similar challenges with data showing that

[1] National Diabetes Statistic Report, Centers for Disease Control and Prevention, January 21, 2026, Retrieved from: https://www.cdc.gov/diabetes/php/data-research/index.html
[2] Overweight & Obesity Statistics, National Institute of Diabetes and Digestive and Kidney Diseases, Retrieved from: https://www niddk nih.gov/health-information/health-statistics/overweight-obesity
[3] Goodson JD, Shahbazi S, Song Z. Physician Payment Disparities and Access to Services-a Look Across Specialties. J Gen Intern Med. 2019 Nov;34(11):2649-2651. doi: 10.1007/s11606-019-05133-0. Epub 2019 Aug 5. PMID: 31385213; PMCID: PMC6848648.

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endocrinologists have the third lowest salary among physicians, below those of primary care groups such as internal medicine and family medicine.[4]

We hope that you will work together in a bipartisan manner to address these challenges. Endocrinologists and other physicians have endured over 30 years of stagnant Medicare reimbursement rates, which have not accounted for inflation or the evolution of office-based medical care. We urge the committee to pass legislation that provides an annual inflationary update to the Medicare Physician Fee Schedule (MPFS) conversion factor (CF). As you may know, CMS has described the Medicare Economic Index (MEI) as the best measure available of the relative weights of the three components of MPFS payments – work, practice expense, and malpractice. We urge you to pass a bill that provides an annual inflation-based adjustment to the CF equal to MEI. We believe that providing this stability is the first step to addressing the reimbursement challenges facing practicing endocrinologists. Additionally, we urge the Committee to explore how Medicare can more appropriately value the work of endocrinologists and other cognitive physicians who provide complex chronic disease management for beneficiaries, particularly when that care is not procedural.

Thank you again for holding this important hearing to shed light on much needed reforms to Medicare physician payment. The Endocrine Society stands ready to work with you to pass legislation that addresses this critical issue. Please do not hesitate to contact us if we can provide additional information.

[4] McKenna, Jon. Comparing Your Pay Against Your Peers': Medscape Physician Compensation Report 2025. Medscape. Published: 2025 July 8. Retrieved from: https://www medscape.com/slideshow/2025-compensation-overview-6018103#3

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Alliance of Specialty Medicine

Sound Policy. Quality Care.

May 20, 2026

The Honorable Brett Guthrie
Chair
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The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
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The Honorable Morgan Griffith
Chair, Health Subcommittee
House Energy and Commerce Committee
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The Honorable Diana DeGette
Ranking Member, Health Subcommittee
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RE: Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms

Dear Chairs Guthrie and Griffith, and Ranking Members Pallone and DeGette,

The Alliance of Specialty Medicine (Alliance) thanks the House Energy and Commerce Subcommittee on Health for holding a hearing on such an important topic. We write to share our ideas about Medicare physician payment reform and opportunities to better measure and reward high value care among physicians. The Alliance, which represents 15 specialty organizations and more than 100,000 physicians, is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. The Alliance greatly appreciates your proactive engagement and willingness to collaborate with us and other stakeholders.

Below we share our recommendations on legislative reforms to improve the Medicare physician payment system, the Quality Payment Program (QPP), and the Center for Medicare and Medicaid Innovation (CMMI).

Medicare Physician Payment Reform (MPFS)

Prior to the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), the costs associated with running a physician practice were on the rise. We continue to see substantial increases in prices for medical supplies, equipment, and clinical and administrative labor, as demonstrated by the Consumer Price Index (CPI) and the Medicare Economic Index (MEI).[1] MACRA established physician payment updates without a yearly automatic inflation adjustment unlike other Medicare providers, which receive annual payment updates based on an inflation proxy, such as the CPI. Given the lack of an automatic payment update, when adjusted for

[1] https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf

inflation in practice costs, Medicare physician payments declined 33% from 2001 to 2025.[2] While Congress anticipated that physicians would receive value-based incentives and differential payment updates based on their participation in either the Merit-based Incentive Payment System (MIPS) or alternative payment model (APM) tracks, many factors have led to insufficient payment updates, particularly when compared to the effort and resources physicians must devote to participate.

The Medicare Trustees[3] and other policy experts have raised concerns about the lack of an inflation measure in the Medicare physician fee schedule (MPFS). According to the Medicare Payment Advisory Commission (MedPAC), this downward financial pressure on physicians has forced many to sell their practices to health systems and private equity groups and enter into employment arrangements with these entities, further consolidating health care systems and increasing health care costs to taxpayers and beneficiaries.[4] Research by the American Medical Association (AMA) found that 42.2% of physicians remained in private practice as of 2024, but many are selling their practices because inadequate payment rates, soaring resource costs, and overwhelming regulatory and administrative burdens make independence increasingly unsustainable.[5]

Beyond the challenges in physician payment created under MACRA, the MPFS is plagued by other challenges, including requirements to maintain budget neutrality and irregularly timed updates to practice expense data used to set payments. In fact, physicians absorbed substantial budget neutrality adjustment prompted by the Centers for Medicare and Medicaid Services' (CMS') 2021 and 2023 implementation of increased relative values for office and outpatient evaluation and management (E/M) services and inpatient and other E/M services, respectively, as well as CMS' 2022 implementation of revised clinical labor prices (an update that lagged two decades). While these adjustments were implemented prospectively, the resulting reductions permanently lowered the MPFS conversion factor baseline. Compounding the issue, CMS relies on prospective utilization assumptions when estimating the budget neutrality impact of newly payable services. However, when those projections overestimate actual utilization, which occurred with Transitional Care Management (TCM) services and the complex care add-on code (HCPCS G2211), the resulting reductions to the MPFS conversion factor (CF) are not subsequently restored.

We appreciate congressional efforts to reduce CF cuts temporarily; however, Congress has still allowed year after year of cuts to the MPFS CF, and this pattern is unsustainable. The 2026 MPFS CF equals $33.40 for non-qualifying APM participants (or $33.57 for qualifying APM participants). In 2016, it was almost $36.00.

The Alliance recognizes that Congress provided a 2.5% increase to the Medicare conversion factor in 2026, but calls on Congress to simultaneously embrace long term reforms to **prevent recurring annual Medicare cuts** and **enact permanent solutions to stabilize Medicare physician payments, support investments in value-based care, and improve the quality of care provided to Medicare beneficiaries.**

Requested Legislative Reforms to the MPFS

The Alliance urges Congress to:

- Provide a permanent, inflation-based update equal to MEI, without reductions or caps.
- Modernize and update the budget neutrality mechanism by increasing the threshold to $54.3 million and indexing it to MEI every five years, requiring that direct cost calculations and valuations be updated every five years in consultation with relevant stakeholders, and limiting year-to-year variance of the conversion factor to 2.5%.

[2] https://fixmedicarenow.org/sites/default/files/2025-01/Medicare Gap Chart_2025.pdf
[3] https://www.cms.gov/oact/tr/2025
[4] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf
[5] https://www.ama-assn.org/practice-management/private-practices/smaller-share-doctors-private-practice-ever

Merit-Based Incentive Payment System (MIPS)

Implementation of MACRA's two-track value-based payment system, the QPP, has been ineffective and, arguably, detrimental to the delivery of most specialty medical care. Many specialists perceive MIPS, in particular, as an enormous administrative hassle that simply diverts critical resources away from more meaningful activities that could directly improve the quality and value of specialty care. Often under MIPS, specialty physicians have no other choice but to report on marginally relevant measures that result in data that is of little use to physicians or their patients. Further, CMS has not produced any evidence to date to suggest that quality, efficiency and outcomes for Medicare's seniors, the disabled, and underserved populations have demonstrably improved as a result of the MACRA-established quality programs.

In contrast to the promises of MACRA, MIPS has evolved into an overly complex, disjointed, burdensome, and clinically irrelevant program for many specialists. Even the Government Accountability Office (GAO), in an October 2021 report,[6] expressed concern that MIPS performance feedback is neither timely nor meaningful, questioned whether the program helps improve quality and patient outcomes, and highlighted the program's low return on investment. In its March 2024 environmental scan of value-based payment models,[7] the Physician-Focused Payment Model Technical Advisory Committee (PTAC) noted: "Overall, there is little evidence that pay-for-performance and public reporting of quality measures have improved overall quality of care in the United States."

The Alliance requests that the Committee consider the following fundamental flaws that continue to plague MIPS:

- **Siloed Performance Categories**. CMS has failed to produce a more unified quality reporting structure, as promised under MACRA. MIPS continues to rely on four separate performance categories that each have distinct and complex reporting requirements and scoring rules, making program compliance extremely resource intensive with little to no evidence of value. Additionally, for many specialties, what is being measured on the quality side rarely aligns with what is being measured on the cost side, resulting in a flawed value equation. The Alliance has repeatedly asked CMS to provide cross-category credit for more comprehensive value-based activities, such as reporting and regularly tracking performance through a clinical data registry, which would minimize duplicative and misguided reporting mandates while rewarding more meaningful investments in value-based care. However, CMS continues to cite statutory constraints, including the mandate to measure clinicians on each of the four MIPS performance categories as dictated by MACRA. As a result, the program is not only challenging to navigate and comply with, but for many specialties, it does not meaningfully reflect the overall value of care.
- **Constantly Shifting Goalposts**. Each year, CMS changes MIPS participation rules, including rules around eligibility, reporting requirements, and available measures. CMS also has the authority to update performance thresholds, which the agency has done many times since the program launched. As a result, it is challenging for physicians to keep up with the program and to make year-to-year comparisons regarding their performance. It is equally challenging for CMS to analyze the overall impact of the program over time accurately.
- **Lack of Incentives for Specialty Measures**. Many specialties have also faced challenges getting more specialty-focused quality measures approved for the program due to excessively burdensome and costly measure testing and maintenance requirements, including those that apply to Qualified Clinical Data Registries (QCDR). QCDRs, in particular, were authorized by Congress to provide a more flexible and rapid pathway for specialties to introduce more innovative and clinically relevant measures under MIPS. Instead, many prominent specialty-sponsored registries have had no other choice but to leave the program. This is unfortunate since clinician-led registries tend to collect more relevant and robust clinical outcomes data, including patient-reported outcomes data, that cannot be captured through claims. They also provide more timely and actionable feedback that is often more meaningful to participating

[6] https://www.gao.gov/assets/gao-22-104667.pdf
[7] https://aspe.hhs.gov/sites/default/files/documents/dae3de25b874112a649445d6381f527e/PTAC-Mar-25-Escan.pdf

clinicians and their patient populations than what is provided by CMS under MIPS. And even when specialty-focused measures are approved for MIPS, our organizations still face challenges getting members to report the measures due to MIPS scoring policies that disincentivize the use of such measures— especially measures such as patient-reported outcomes measures, which are more time-consuming to collect, but more meaningful to patients and physicians.

- **Barriers to Accessing Claims Data.** Specialty societies and QCDRs have also faced major challenges in accessing claims data. Claims data acquisition is costly and time-consuming, and specialty societies continue to face delays in trying to access such data. Specialty societies are willing to assist CMS with more robust quality and cost analyses but cannot do this without reasonable access to timely Medicare claims data.
- **Flawed Cost Measures**. Cost measures adopted for MIPS are also extremely difficult to interpret and take meaningful action on, and efforts to implement cost measures under MIPS to date have uncovered a variety of complex issues that make physician-level accountability an ongoing challenge. They often reflect care decisions and costs that are outside of an individual physician's direct control and rarely align directly with quality measures other than in the title. While Total Cost measures are the most problematic, even more focused episode-based cost measures often hold physicians responsible for costs that they cannot control. For example, autoimmune diseases such as rheumatoid arthritis and Crohn's disease are managed with highly complex medications, including biologics, that physicians have little control over. Depending on the patient's unique biology, disease progression, and other clinical factors, one therapy may be clinically indicated, recommended and prescribed over another. Additionally, MIPS cost measures to date have measured cost of care *in isolation*, failing to account for the impact that changes in spending have on care quality and access to care. This is even true under CMS' new MIPS Value Pathways (MVP) Framework, which was intended to align performance assessment across the four MIPS performance categories. Unfortunately, MVPs too often include a cost measure addressing a specific condition, but no corresponding quality measure that addresses the same condition/ population. Therefore, it is not clear if the MIPS participant achieved good cost performance by improving value, or by simply holding back on appropriate care.
- **Lack of Flexibility to Promote Interoperability**. The MIPS Promoting Interoperability category continues to take a one-size-fits-all approach to care that fails to appreciate the diversity and readiness of practices across the nation. The category also continues to focus on very specific EHR functionalities rather than promoting innovative use cases of health information technology, such as clinical data registries, clinical decision support tools, and tracking data from wearables and other digital devices that are more common among specialty patients. EHR adoption and federal policies supporting interoperability have advanced significantly since the enactment of MACRA. There is much more widespread use of CEHRT among clinicians, and CEHRT requirements have evolved to a point where users of CEHRT are inherently satisfying the actions that the current set of MIPS Promoting Interoperability measures originally set out to capture and incentivize (e.g., secure data exchange). Where they are not, it is not the fault of the clinician, but the EHR vendor or institution deploying the technology. As a result, this category of MIPS has become outdated and should be revised to better represent the current landscape and minimize unnecessary reporting burden.
- **Failure to Provide a Glidepath to APM Participation**. The intent of MIPS, as envisioned by MACRA, was to prepare physicians to move into APMs. However, the current program — even as revised through the MVP Framework — largely fails to align with measures used under APMs and does little to ready specialists to move into APMs. Further, there are ongoing barriers to APM participation among specialists, as explained earlier.
- **Misguided Efforts to Improve MIPS**. Although CMS' MVP Framework was intended to address many of the problems outlined above, it simply reshuffles the deck while doing very little to address the program's foundational flaws, which increases frustration and disillusionment among physicians at a time when physician burnout is at an historical high. Compounding these concerns, CMS recently finalized a new mandatory APM – the Ambulatory Specialty Model (or ASM) – which builds directly on the MVP framework, despite widespread concern among specialties that MVPs do little to address the

shortcomings of traditional MIPS. As noted in our comments to CMS[8], the Alliance believes the model further exacerbates existing flaws in MIPS rather than creating a true path forward for specialists to engage meaningfully in value-based care. For these reasons, the Alliance strongly urges Congress to prohibit CMS from implementing the Ambulatory Specialty Model. Instead, CMS should work collaboratively with specialty societies to design models that are grounded in clinically meaningful measures, structured to incentivize rather than mandate participation, and aligned with a pathway to Advanced APM participation.

Requested Legislative Reforms Related to MIPS

The Alliance urges Congress to:

- Give CMS the authority to move beyond the four siloed performance categories of MIPS and instead recognize more comprehensive and innovative investments in high value care.
- Better recognize the value of clinical data registries and their role in the QPP by, for example, allowing clinicians to receive credit across all four MIPS categories for registry participation that meets minimum standards and recognizing similar participation pathways that are more meaningful to specialists.
- Require CMS to better incentivize the development and use of specialty-focused metrics through technical assistance, less resource-intensive measure testing policies, and revised MIPS scoring policies that promote the reporting of such measures.
- Allow physicians to meet Promoting Interoperability requirements via "yes/no" attestation of using Certified Electronic Health Record Technology (CEHRT) or technology that interacts with CEHRT, such as participation in a clinical data registry. Since MACRA was first signed into law, the Office of the National Coordinator for Health Information Technology (ONC), in collaboration with CMS, has finalized numerous regulations intended to better support the electronic exchange of data, incentivize the use of technology, and promote interoperability. In the most recently issued HTI-5 proposed rule,[9] ONC even proposes to significantly streamline requirements imposed on EHR vendors under the Health Information Technology Certification Program, acknowledging that efforts to incentivize interoperability have evolved and that many program requirements are now either obsolete or have become market baseline. Requirements imposed on clinicians should similarly recognize the maturity of EHR adoption and aim to minimize reporting burden. The majority of impediments to further progress in this space are not in the direct control of physicians, but rather EHR vendors and the facilities or health systems in which physicians practice.
- Allow CMS to modify the MIPS Cost category by:
    - Removing the primary care-based total per capita costs measure mandate in MACRA that continues to hold physicians — including specialties that are explicitly excluded from the measure — responsible for costs outside of their control.
    - Removing the MACRA requirement that episode-based cost measures account for at least half of Part A and B expenditures to ensure prioritization of episodes with high variability and that specialists can directly impact.
    - Requiring that any evaluation of cost also simultaneously accounts for any changes in quality indicators meaningfully tied to cost performance, including within the same patient population, to ensure cost-containment efforts do not result in poorer quality care or negatively impacts access to care (i.e., true measures of value).
- Enforce MACRA's requirement that CMS provide access to Medicare claims data to assist specialties and their registries with a better understanding of existing gaps in care and support the development of quality and cost measures.
- Require CMS to release more granular and timely data regarding physician participation in MIPS.

[8] https://specialtydocs.org/wp-content/uploads/2025/09/Alliance_CY-2026-MPFS-Comments_FINAL-submitted.pdf
[9] 90 FR 60970

The Center for Medicare and Medicaid Innovation (CMMI) and Alternative Payment Models (APMs)

CMS has released very little specialty-specific APM data to date, making it challenging to fully understand the availability and impact of these models on specialists, as well as barriers to engagement. While CMS' annual QPP Experience Report[10] and associated QPP Public Use Files (PUF)[11] include comprehensive participation and performance data related to the MIPS, it only includes aggregate national data on the total number of clinicians that were QPs in an Advanced APM. It does not provide any detailed breakdown of QP status or APM participation by specialty or by practice type (e.g., small practice, rural, facility-based, etc.).

In addition, most specialty physicians have struggled to meaningfully engage in the Advanced APM track of the QPP, as there are only a few APMs that are applicable to specialty care and meet the Advanced APM criteria. Through discussions with Alliance member organizations and the physicians they represent, we have found that accountable care organizations (ACOs) are often the only option for APM engagement. However, the decision to participate in an ACO is often made by a specialist's hospital or health system, or a result of healthcare consolidation, and the specialist's role in the model is often passive. Additionally, specialists do not have an opportunity to meaningfully engage in quality improvement or cost containment activities specific to their patient population since ACO measures do not reflect the conditions they treat or the services they provide.

As a result, active and meaningful engagement in APMs is nearly impossible. Previously tested specialty-focused APMs (e.g., the Bundled Payments for Care Improvement–Advanced (BPCI-A)) have only targeted a limited number of conditions or procedures and failed to provide high-performing practices with an incentive to stay in the model due to exceedingly challenging spending targets that simply do not support high quality, appropriate care. More recently announced models, such as the Ambulatory Specialty Model (ASM), are mandatory and were developed without specialty society input. As a result, specialists are increasingly being forced to participate in models that rely on misguided measures and methodologies.

The Alliance appreciates CMMI's recent recognition that a comprehensive approach to accountable care must account for both primary care and specialty care and that it is exploring opportunities to build on the "shadow bundle" concept where specific episode-based or condition-specific models are nested in population-based total cost of care (PB-TCOC) models. However, we are concerned that these initiatives are being rolled out without broader specialty engagement or input and may offer limited opportunities for meaningful specialist involvement. Some Alliance member organizations have already invested in this type of work, yet they continue to face challenges in terms of getting CMS to adopt these models.

The Alliance is disappointed with the ongoing lack of models and relevant participation pathways for specialists. We are also frustrated by the limited opportunities that specialists have had to date to become Qualifying Participants (QPs) in Advanced APMs under the QPP. As a reminder, under current law, the QP thresholds are scheduled to increase and the APM incentive is scheduled to end starting with the 2027 performance year/2029 payment year, as reflected below:

QP Thresholds

- 2022/2024: 50% Part B Payments/ 35% Part B Patients
- 2023/2025: 50% Part B Payments/ 35% Part B Patients
- 2024/2026: 50% Part B Payments/ 35% Part B Patients
- 2025/2027: 75% Part B Payments/ 50% Part B Patients
- 2026/2028: 50% Part B Payments/ 35% Part B Patients
- 2027/2029: 75% Part B Payments/ 50% Part B Patients

[10] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3269/2023-QPP-Experience-Report.pdf
[11] https://qpp.cms.gov/resources/performance-data

APM Incentive Payment

- 2022/2024: 5%
- 2023/2025: 3.5%
- 2024/2026: 1.88% (+ differential CF update for QPs (0.75%) vs. non-QPs (0.25%))
- 2025/2027: No incentive payment; just differential CF update
- 2026/2028: 3.1% (+ differential CF update)
- 2027/2029: No incentive payment; just differential CF update

The Alliance very much appreciates that Congress has acted multiple times to freeze the QP threshold and extend the APM incentive payment. However, without a further extension of these provisions, many specialists will never have had an opportunity to benefit from the APM incentive payment, which allows physicians to invest in the infrastructure and analytics needed to engage successfully in such models and provide higher value care. These shifts in policy contradict the Congressional intent of MACRA, which was to encourage clinician movement into APMs, using MIPS as a springboard, not as a long-term solution. Unfortunately, these changes also come at time when we are finally starting to see measurable progress in terms of the number of clinicians moving into Advanced APMs. The 2024 performance year was the first time since the enactment of MACRA that the number of QPs exceeded the number of MIPS eligible clinicians. Although we do not know what proportion of QPs have been specialists, without additional Congressional action, we expect to see a reversal in this progress and potentially a situation where MIPS incentive payments begin to exceed APM incentive payments, causing movement away from APMs, contrary to Congress' vision.

Requested Legislative Reforms Related to the CMMI and APMs

The Alliance urges Congress to:

- Require CMS to release more granular and timely data regarding specialty participation in CMMI-tested models and other CMS alternative payment models (APMs); the impact of those models on quality, value, and access to specialty care; and eligibility for the Advanced APM track of the QPP by specialty.
    - As a starting point, Congress should direct GAO to conduct a study on APMs that documents gaps in current availability of APMs for specialists, identifies current barriers to specialist participation in APMs, collects insights from specialists and other physicians on how they would like to see APMs designed, and evaluates more specifically the reasons why specialty-focused models have not moved forward.
- Require CMMI to employ more transparent processes when developing and evaluating models. Specifically, CMMI should be required to consult with potentially impacted stakeholders prior to implementing a model and be required to publish a notice of model concepts early in the model development phase. This would promote greater transparency in model design and ensure all stakeholders have an opportunity to meaningfully engage with CMMI on the development of models. Similarly, CMMI should be required to publicly explain why adopted models are terminated early or not expanded to identify lessons learned in order to inform future models. CMMI should be held accountable to Congress and the public in a manner that builds trust in these processes, but is not so cumbersome as to stifle progress and innovation.
- Congress should also require CMMI to work collaboratively with specialty societies to improve the APM pipeline. This could include requiring CMMI to technical assistance and more specific guidance to specialists and their societies on how to get APMs approved for testing. Specialty societies have invested significantly in the development of models that have been repeatedly rejected or ignored.
- For population-based models that have been more geared toward primary care, such as ACOs, provide model entities with technical assistance that would allow them to appropriately analyze clinical and administrative data, improving their understanding of the role specialists play in addressing complex health conditions, such as preventing acute exacerbations of comorbid conditions associated with chronic disease.

- Extend opportunities for specialists to meet the eligibility criteria to become a QP in an Advanced APM under the QPP. Restore and extend the full 5% APM incentive payment, as well as the lower QP thresholds to facilitate specialty physician movement into Advanced APMs, including new and more relevant models that have not yet materialized.
- Terminate the deeply flawed Ambulatory Specialty Model (ASM) recently finalized by CMS.

Thank you for your ongoing leadership in addressing Medicare physician payment and quality programs. We welcome the opportunity to work with you on these important issues. If you have any questions, please do not hesitate to contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists
Society of Interventional Radiology

Association of Black Cardiologists
Written Statement for the Hearing Record May 20, 2026
Energy & Commerce Committee Subcommittee on Health
"Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms"

On behalf of the Association of Black Cardiologists (ABC) thank you for this opportunity to submit this written statement for the record for the May 20, 2026 **Subcommittee on Health hearing titled "*Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms*."** ABC appreciates the Subcommittee's commitment to addressing affordability in healthcare and its specific examination of **"**Medicare physician payment issues and reforms enacted in MACRA." ABC stands ready to be a resource to the Subcommittee and the full Energy & Commerce Committee as you all continue your efforts to ensure that healthcare is affordable and accessible to all Americans, particularly those individuals at risk for and living with cardiovascular disease (CVD).

About the ABC

Founded in 1974, ABC is a nonprofit organization with a global membership, including health professionals, community health advocates, and institutional members. ABC's mission is to promote the prevention and treatment of CVD, including stroke. Through education, research, partnerships, and advocacy, ABC seeks to advance cardiovascular health and improve outcomes in communities nationwide. ABC works tirelessly to ensure access to the care, services, screening, and diagnostic tests recommended in the American College of Cardiology-American Heart Association practice guidelines for individuals at risk for and living with CVD. As part of our efforts, ABC engages in federal policy and advocacy efforts to ensure Medicare beneficiaries have access to critical cardiovascular breakthrough treatments, new technologies, and innovative products—such as those targeting lipoprotein (a) and LDL cholesterol—to address residual cardiovascular risk and improve outcomes for high-risk populations.

Background

CVD is the leading cause of death in the U.S. for men, women, and people of most racial and ethnic groups.[1] Each year, approximately 695,000 Americans die from heart disease—accounting for one in every five deaths, or roughly one person every 33 seconds.[2] Studies estimate that CVD costs the U.S. $219 billion annually, including $147 billion in lost productivity.[3] By 2050, these costs are projected to reach approximately $2 trillion.[4] Cardiac events and strokes are closely linked, with strokes accounting for one in six deaths caused by CVD. [5] Between 2019 and 2020, stroke-related healthcare costs alone totaled nearly $56.2 billion.[6] Given these staggering figures, physician reimbursement and other Medicare policies, such as prior authorization, have a

[1] Heart Disease Facts. Centers for Disease Control and Prevention.
https://www.cdc.gov/heart-disease/data-research/facts-stats/?CDC_AAref_Val=https://www.cdc.gov/heartdisease/facts htm
[2] Ibid.
[3] Fast Facts: Health and Economic Costs of Chronic Conditions.
https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html#cdcreference_4
[4] Ibid.
[5] Stroke Facts. Heart Disease Facts. Centers for Disease Control and Prevention.
https://www.cdc.gov/stroke/data-research/facts-stats/index.html
[6] Ibid.

significant impact on timely access to preventive care and treatment. Policies that thwart or delay access not only worsen patient outcomes but also unnecessarily increase healthcare spending. As Congress considers reforms to Medicare policy—both traditional Medicare (fee-for-service) and Medicare Advantage (MA)—it is imperative to prioritize early intervention, robust chronic disease management, and expanded access to medically necessary care to save lives and reduce costs.

Of particular concern to ABC is that more than 16.8 million Black Americans—approximately one in three—live in U.S. counties with limited or no cardiology care and more than two million reside in areas without a single cardiologist.[7] Known as "cardiology deserts," these geographic areas include both rural and underserved urban communities as well as poor areas. Cardiology deserts are heavily concentrated in southern states like Mississippi, Louisiana, Georgia, and Arkansas.[8] Those living in cardiology deserts experience higher rates of heart disease, driven by limited access, poverty, and systemic health inequities.[9] In total, cardiology deserts affect nearly 22 million Americans and research has found that nearly half of U.S. counties (86.2% of rural counties) lack a single cardiologist—underscoring a significant and growing public health concern.[10] Persistent Medicare payment instability, marked by stagnant or declining reimbursements amid-rising practice costs, threatens the viability of practices serving high-need, underserved populations. This instability harms small and mid-sized practices in cardiology deserts and communities with high proportions of Black and low-income Medicare beneficiaries.

In addition to these challenges, our nation faces an overall shortage of practicing physicians and a significant contributing factor to the shortage is physician burnout due to administrative burdens and utilization management (UM) practices such as prior authorization (PA) requirements by MA and commercial plans. Administrative requirements associated with UM compliance are a major contributor to clinician dissatisfaction and escalating staffing expenses.[11] On average, physician practices complete 40 PA requests *per physician* per week, requiring approximately 13 hours of non-patient-facing-administrative time weekly.[12] Moreover, as increased formulary restrictions are imposed by MA plans, the need for PA to achieve patient treatment goals will undoubtedly increase as well.

To keep up with the administrative workload and care demands, some healthcare practices and systems have resorted to hiring dedicated staff to handle PA requests. In settings that cannot afford this, the burden falls directly on providers or existing office staff. In all cases, these administrative

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[7] More Than 16 Million Black Americans Live in Counties With Limited or No Access to Cardiologists. May 2023. https://www.goodrx.com/healthcare-access/research/black-americans-cardiology-deserts
[8] Cardiology Deserts Campaign: The Urgent Need. Association of Black Cardiologists. https://cardiologydeserts.org/
[9] Ibid.
[10] Research Letter: Geographic Disparities in Access to Cardiologists in the United States. July 2024. Geographic Disparities in Access to Cardiologists in the United States - ScienceDirect
[11] American Medical Association. Prior authorization physician survey and progress report. 2025. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[12] Ibid.

requirements consume significant time and attention, both during and outside of clinical hours.[13] Additionally, PA requests are often reviewed by individuals or artificial intelligence tools used by MA plans that lack the clinical expertise of the treating physician. This often leads to inappropriate denials, undermines clinical judgment, and causes unnecessary care delays, further compounding frustration and stress for both providers and patients.

Furthermore, current UM practices used by MA plans divert valuable time and resources away from patient care and contribute to burnout and financial pressure facing physicians, particularly those in small and mid-sized practices that serve rural and underserved communities. Eighty-eight percent of physicians surveyed by the American Medical Association assert that PA leads to higher overall utilization of healthcare resources; nearly 50% indicate PA contributes to more urgent care and ER visits while 73% report additional offices visits due to the PA process.[14] As the nation faces a mounting healthcare workforce shortage—including a projected shortfall of nearly 9,000 cardiologists—it is essential to reduce administrative burden and preventable office and ER visits so clinicians can focus on what they do best: delivering high-quality, timely care for those in need.[15]

Policy Solutions

Medicare payment policy has a direct, significant impact on access to care for the estimated 66 million Americans in the program,[16] as the Medicare Trustees in their 2025 report noted,

> "While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from the SGR [Sustainable Growth Rate] system approach, **it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation** [emphasis added]. The law specifies the physician payment updates for all years in the future, **and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases** [emphasis added]. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. **Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term** [emphasis added]."[17]

As such, Congress must take action to ensure that Medicare payment policy sustains the nation's physicians so that individuals served by Medicare can maintain access to both primary and

[13] Ibid.
[14] Ibid.
[15] Health Resources & Services Administration. Health Workforce Projections. U.S. Department of Health and Human Services. November 2024. https://bhw hrsa.gov/data-research/projecting-health-workforce-supply-demand
[16] Medicare. Retrieved May 2026. https://www.medicare.gov/about-us
[17] Centers for Medicare and Medicaid Services. Retrieved May 2026. https://www.cms.gov/oact/tr/2025

specialty care. Providing adequate reimbursement for physician services and ensuring sufficient resources for Medicare graduate medical education (GME) will sustain the current physician workforce and ensure an adequate pipeline to care for the patients of tomorrow. To strengthen the healthcare workforce and support clinicians in rural and underserved communities, ABC respectfully urges the Subcommittee to consider the following proposals:

- The **Medicare Patient Access and Practice Stabilization Act (S. 1816/H.R.879)** to ensure continuity of—and access to—primary and specialty care.
- The **Provider Reimbursement Stability Act (H.R. 8163)** to modernize and update the Medicare Physician Fee Schedule to ensure appropriate reimbursement for physicians, which in turn, facilitates patient access to primary and specialty care, including CVD diagnosis, management, devices, and other care and treatment.
- The **Improving Seniors' Timely Access to Care Act (S. 1816/H.R. 3514)** to require MA plans to have electronic systems in place to streamline their prior authorization and appeals processes, to reduce clinician burden and facilitate patient access to care.
- The **Resident Physician Shortage Reduction Act of 2025 (S. 2439/H.R.4731),** which will help address the current and anticipated physician shortage by increasing the number of Medicare-supported residency positions by 2,000 per each fiscal year from FY 2026 through FY 2032.

In addition to these physician-specific measures, ABC asks the Subcommittee to consider these additional policies, which will improve access to care for Medicare beneficiaries with CVD and, in turn, reduce costs, decrease healthcare utilization, and help leverage the existing physician workforce in a more efficient manner:

- The **Amputation Reduction and Compassion (ARC) Act (H.R. 307)** to expand Medicare and Medicaid coverage of peripheral artery disease (PAD) screening among at-risk beneficiaries without cost-sharing requirements.
- The **Ensuring Patient Access to Critical Breakthrough Products Act (S. 1717/H.R. 5343)** to ensure Medicare beneficiaries have prompt access to coverage and reimbursement of approved FDA-designated breakthrough- devices.
- The **Maintaining Investments in New Innovation (Mini) Act (H.R. 1672)** to accelerate continued innovation and access to genetically targeted technologies.
- Legislation to provide Medicare reimbursement for self-measured blood pressure monitoring devices that provide a cost-effective way to assist in the management of high blood pressure and lead to improved cardiovascular health.
- Legislation to waive Medicare cost-sharing for chronic disease management, remote patient monitoring, and other similar efforts to help patients manage CVD and other chronic diseases.
- Legislation to provide Medicare reimbursement for coronary calcium score testing for early detection of atherosclerotic plaque in beneficiaries at risk of developing coronary artery disease, such as individuals with the following risk factors: diabetes, high blood pressure, high cholesterol, and/or a family history or premature coronary artery disease.

Lastly, we respectfully ask the Subcommittee to urge CMS to take the following actions, which will improve health outcomes for Medicare beneficiaries with CVD:

- Align Medicare coverage with American College of Cardiology and American Heart Association-recommended practice guidelines with respect to the management of dyslipidemia, such as, but not limited to, establishing an LDL-C Medicare quality measure (threshold below 70 mg/dL) to encourage and incentivize better treatment and monitor the effectiveness of and adherence to cholesterol-lowering therapies.
- Retire the Coverage with Evidence Development (CED) on Transcatheter Aortic Valve Replacement (TAVR) and issue an affirmative National Coverage Determination (NCD) according to its FDA-approved indications, as existing data demonstrates that there is no longer a relationship between volume and health outcomes.
- Enable broad and timely access to Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER) for all Medicare beneficiaries who may benefit to promote patient-centered care and ensure that beneficiary access to promising new therapies is not limited by geography, or burdensome procedural criteria (e.g., volume thresholds).
- Promulgate an inclusive Medicare coverage determination for Transcatheter Tricuspid Valve Replacement (TTVR) that ensures equal access to TTVR for all patients, especially those in underserved communities, including by streamlining evaluation requirements and removing arbitrary volume thresholds.
- Expand Medicare coverage of cardiac rehabilitation for patients with heart failure with preserved ejection fraction (HFpEF), based on emerging clinical evidence, to improve access to supervised exercise therapy and support improved quality of life and outcomes for a broader population of heart failure patients.
- Direct the Center for Medicare & Medicaid Innovation (CMMI) to develop and implement a new model that incorporates PAD screening for high-risk individuals into the annual Medicare Wellness Visit, with no beneficiary cost-sharing.
- Continue to test and advance payment models that prioritize whole-person and preventive care, including but not limited to: the Ambulatory Specialty Model (ASM), the Advancing Chronic Care with Effectiveness, Scalable Solutions (ACCESS) Model, and the Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence (MAHA ELEVATE) Model that aim to modernize prevention, improve chronic disease and cardiology outcomes, and test value-based payment and care delivery approaches.

Conclusion

The ABC thanks you for your leadership; we appreciate your holding a hearing to discuss physician reimbursement and workforce challenges. Increasing physician payment, expanding Medicare GME, and ensuring Medicare coverage for a range of CVD prevention, screening, diagnosis, management, and treatment care and services will help ensure that beneficiaries have improved outcomes, which in turn will decrease healthcare spending and utilization. ABC welcomes the opportunity to work with you and your colleagues to ensure that Medicare beneficiaries have access to the primary and specialty care they need and deserve.

AAOE
American Alliance of Orthopaedic Executives

May 19, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2123 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2123 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Griffith and Ranking Member DeGette,

On behalf of the American Alliance of Orthopaedic Executives (AAOE), I write to thank you for holding this important hearing on "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms." AAOE shares the Chairman's goal of working to improve care for the nation's seniors. We believe this hearing is a critical step forward in addressing the ongoing challenges associated with the current Medicare payment system.

AAOE represents over 1,300 members and 660 medical practices across the country whose mission is to promote quality health care practice management in the orthopedic and musculoskeletal (MSK) industry.

AAOE advocates for stable, predictable reimbursement that allows orthopedic and MSK practices to remain financially viable and continue serving their communities. This includes supporting annual inflationary updates to the Medicare Physician Fee Schedule, addressing systemic downcoding and payer denials, and promoting payment policies that reflect the true cost of delivering MSK care. Without these safeguards, patients face reduced access to care and increased pressure to consolidate—outcomes that ultimately harm patients, employers, and local economies.

MACRA Background and Ongoing Challenges

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) fundamentally reformed Medicare physician payment by repealing the Sustainable Growth Rate (SGR) formula and replacing it with a new system of annual payment updates. It created the Quality Payment Program (QPP), which ties clinician reimbursement to performance through two pathways: the Merit-Based Incentive Payment System (MIPS) and advanced Alternative Payment Models (APMs).

While well-intentioned at the time, MACRA—particularly through MIPS—has created significant administrative and financial burden for providers, requiring extensive data collection, reporting, upfront and ongoing investment in IT infrastructure, and compliance activities to avoid penalties. The American Medical Association (AMA) reports that compliance costs $12,800 per physician per year and that physicians spend 53 hours per year on MIPS-related tasks.

Medicare reimbursement has not kept up with the cost of inflation. Staffing, infrastructure, medical supplies, and technology costs have continued to rise. Adjusted for inflation in practice costs, Medicare physician payment has declined 33% from 2001 to 2025. Moreover, the budget-neutral "tournament" structure in which provider bonuses are funded by penalties imposed on others, exposes providers to payment cuts of up to 9%. It is notable that non-primary care specialties, such as MSK, have the lowest number of reportable measures, which may negatively impact their scores. The $20 million budget neutrality threshold exacerbates payment reductions when triggered—most notably those experienced with the increases to outpatient evaluation and management service codes in 2021, which continue to present reimbursement cuts annually absent congressional intervention. Congress sought to prevent these annual cuts to Medicare reimbursement and associated uncertainty with the repeal of SGR. Unfortunately, ten years later, we are facing similar challenges.

In orthopedics and the broader MSK space, these challenges are amplified. MIPS measures often fail to reflect procedural complexity, and specialties like orthopedics have fewer relevant measures available—putting them at a disadvantage.

Additionally, limited availability of specialty-relevant **voluntary** APMs has left many MSK providers with no viable pathway out of MIPS.

MACRA Reform

The current payment system is unsustainable and does not provide the adequate and predictable reimbursement structure needed to keep MSK providers solvent. AAOE believes the following principles should guide congressional MACRA reform efforts.

- **Congress must provide an annual update to Medicare physician payment.** Currently, the annual update to the physician fee schedule is inadequate and fails to account for the costs and challenges that MSK providers face. At a minimum, Congress should provide an annual inflationary update based on the Medicare Economic Index.

- **Congress must eliminate the 2 percent Medicare sequestration**. The Medicare sequestration punishes providers for fiscal concerns outside of their control. Congress should eliminate this arbitrary "tax."

- **Reduce administrative burden under MIPS.** If the MIPS program continues, reforms should include streamlining reporting requirements, limiting redundant data collection, aligning measures across programs, and prioritizing clinically meaningful metrics—particularly for procedural specialties such as MSK—to lower compliance costs and allow providers to focus on patient care.

- **Avoid mandatory APMs.** While supportive of the transition from MIPS to APMs, AAOE does not support untested mandatory APMs. Mandatory APMs essentially force MSK providers into financially risky arrangements that could threaten their viability. Financial incentives are critical to successfully participate in models—this includes Congress extending the incentive bonus for APM participation. Ultimately, APMs should be physician-led and designed to provide support to providers via financial incentives and regulatory flexibilities.

Conclusion

AAOE appreciates the Subcommittee's interest on this critical issue. We urge that Congress consider Medicare payment reforms that will improve stability, reduce burden, and expand access to high-quality MSK care. We look forward to being a resource. If you have any questions, please contact Chris Roy, Advocacy Council Chair at advocacy@aaoe.net.

Sincerely,

Terry Rosenthal, MBA, ATC
2026-2027 AAOE President

Chris Roy, M.Ed, ATC, LAT
2026-2027 AAOE Advocacy Council Chair

Written Testimony of the American Society for Radiation Oncology (ASTRO)

Before the U.S. House of Representatives

Committee on Energy and Commerce, Subcommittee on Health

Hearing: "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms"

May 20, 2026

Chairman Guthrie, Chairman Griffith, Vice Chair Harshbarger, Ranking Member Pallone and Ranking Member DeGette, and Members of the Subcommittee, thank you for the opportunity to submit testimony for the record.

The American Society for Radiation Oncology (ASTRO) is the national medical society representing more than 10,000 radiation oncologists, medical physicists, radiation therapists, dosimetrists, and other professionals who deliver radiation therapy to patients in every state and in communities of all sizes. We greatly appreciate the Committee holding this important hearing and its efforts to reform Medicare physician payments to protect and enhance patient access to high quality care.

Radiation therapy is a cornerstone of modern cancer care and one of the most cost-efficient treatments available. Today, however, long standing flaws in Medicare physician payment for radiation therapy are making cancer care less affordable to deliver and for patients to receive. These structural problems, combined with significant revisions to the radiation treatment delivery code set this year, have boiled over into a full-fledged payment crisis. Together, these dynamics are increasing the cost of delivering care, forcing clinics to reduce services or close, and shifting financial and access burdens directly onto patients and families.

ASTRO urges Congress to address these urgent challenges through targeted structural reform, specifically the Radiation Oncology Case Rate Value-Based Program Act (H.R. 2120/S. 1031), or ROCR Act, which was designed to stabilize payment, protect patient access, improve affordability, and generate Medicare savings. The bill is led by bipartisan Committee members John Joyce, MD (R-Pa.) and Paul Tonko (D-N.Y.), as well as Representatives Brian Fitzpatrick (R-Pa.), Jimmy Panetta (D-Calif.) of the Committee on Ways and Means and Senators Thom Tillis (R-N.C.) and Gary Peters (D-Mich.).

Medicare Payment Flaws Are Driving an Affordability Problem for Radiation Therapy

For many years, ASTRO has warned that the Medicare Physician Fee Schedule (MPFS) does not reflect the realities of modern radiation oncology, noting that total allowed charges for radiation therapy have dropped by 27% since 2013. Radiation therapy is capital intensive, delivered through clinically defined episodes of care and depends on specialized infrastructure and

staffing. Yet Medicare largely pays for these services through a fragmented fee for service system that was not designed to account for high fixed costs in a predictable way.

The Centers for Medicare and Medicaid Services (CMS) itself acknowledged in the CY 2026 MPFS Proposed Rule the challenges of using the MPFS methodology for radiation therapy given its specialized, capital-intensive resources are "difficult to compare" to those involved in furnishing other services in physician offices. CMS noted that the machine and room used for radiation therapy are priced at nearly $4 million—well more than twice the price of the next most expensive equipment in the MPFS.

This matters for affordability because when payment methodology cannot reliably recognize the true resource profile of radiation therapy, clinics face an ongoing squeeze between rising operating expenses and unstable reimbursement. That drives delayed investment, reduced capacity, and higher per patient overhead costs that ultimately affect patient access and affordability.

CMS also has recognized that the resources involved in furnishing radiation treatment delivery services are driven by capital costs that are not likely to vary greatly between hospitals and freestanding centers, and that the structure of the billing codes makes use of hospital outpatient cost data particularly appropriate. Consistent with those realities, CMS finalized a significant policy change for 2026 to use the relationship between hospital outpatient Ambulatory Payment Classification relative weights to inform valuation of revised radiation treatment delivery codes under the MPFS. ASTRO supports this well-intentioned policy direction but is concerned by flaws in its execution that have undervalued these services in the hospital setting and has led to a payment crisis impacting both hospitals and freestanding radiation therapy centers.

Aligned with CMS' policy direction, ROCR would use hospital outpatient payment data as a transparent and predictable foundation for a unified episode-based payment that applies consistently across hospital outpatient departments and freestanding radiation therapy centers, reflecting the reality that the costs of delivering radiation therapy are fundamentally driven by high fixed investments and specialized staffing that are similar across settings.

2026 Payment Crisis Worsening Affordability for Clinics and Patients

The long-standing flaws described above have been intensified by the 2026 disruption associated with the revised radiation treatment delivery codes that CMS implemented January 1, 2026. Early experience shows that revised reimbursement rates are causing significant financial distress and access to care concerns. The consequences of this crisis are no longer a possibility or theoretical.

In April 2026, the Mississippi Free Press reported that the Alliance Cancer Center radiation clinic in Greenville, Mississippi will close June 1, forcing cancer patients in the Mississippi Delta to travel up to two hours each way to receive radiation therapy. Because radiation therapy is typically administered several times a week for multiple weeks, having access to a nearby clinic is critical. A lengthy two-hour drive each way can pose significant cost and convenience challenges, particularly for those who are ill or elderly. The potential closure of these clinics highlights how instability in Medicare payments can make it much more difficult for patients in rural and medically underserved areas to receive timely cancer treatment.

Clinicians and cancer center leaders across the country describe similar pressures. As one radiation oncologist leading a large freestanding network that already closed one clinic explained:

> "We need help urgently or this crisis will grow and more centers will close."

For patients, affordability is inseparable from access. According to the executive director of a freestanding rural nonprofit cancer center:

> "Community Cancer Center is the only radiation therapy provider in our region. Without it, patients would face a two to three hour round trip every day for treatment. For many elderly or financially vulnerable patients, that means delayed care, incomplete treatment, or no treatment at all."

These real-world impacts demonstrate how payment instability translates into higher costs for patients through increased travel, lost work time, delayed treatment, and reduced access to local care.

Why ROCR Is the Necessary Affordability and Stability Fix

The affordability challenges facing radiation oncology are structural and require a structural solution. Incremental fee schedule adjustments cannot correct a payment system that is fundamentally misaligned with modern radiation therapy. ROCR was developed to address these issues directly.

ROCR Improves Affordability for Clinics Through Payment Stability

ROCR transitions Medicare payment for radiation therapy from a per service model to a predictable, episode-based case rate. This design reduces year-to-year volatility and allows clinics to plan investments in staffing, safety, and technology more efficiently.

ROCR aligns payment incentives with evidence based clinical guidelines. Clinics are not penalized for delivering shorter courses of care, when appropriate. Instead, the model supports

efficient care delivery by design, which improves affordability by reducing inefficiencies, lowering overhead costs, and supporting sustainable community-based practice.

ROCR also incorporates accreditation-based quality incentives and avoids excessive administrative burden—in sharp contrast to the MIPS program. Reduced administrative complexity is itself an affordability improvement because it lowers non-clinical costs that do not contribute to patient care.

ROCR Improves Affordability for Patients by Protecting Access Close to Home and Reducing Burden

For patients, affordability means predictable access to care without unnecessary travel, delay, or financial burden. ROCR was designed to keep radiation therapy available in community settings and to prevent avoidable closures of local clinics.

The connection between clinic affordability and patient harm is clear. As one community radiation oncologist serving a rural population explained:

> "Without payment stability, centers like mine which serve vulnerable populations will disappear. We are very near the tipping point, and once we're gone, patients will suffer tremendously."

ROCR also includes features intended to improve access for rural and underserved patients, including support for transportation needs. By preserving local capacity and reducing treatment burden where clinically appropriate, ROCR helps make cancer care more affordable for patients and families.

ROCR Controls Costs and Improves System Wide Affordability

ROCR was designed to generate Medicare savings through disciplined, prospective cost control embedded directly into episode payments. The legislation is designed to save Medicare more than $200 million over ten years, with a Congressional Budget Office score pending.

ROCR achieves savings without increasing beneficiary cost sharing, reducing benefits, or destabilizing care delivery. Cost control, access preservation, and provider participation reinforce each other under this model rather than conflict.

Broad Bipartisan and Stakeholder Support

ROCR has bipartisan support in Congress, with more than 30 cosponsors, including 10 on the Energy and Commerce Committee. The legislation has backing from a broad coalition of stakeholders, including professional societies, hospitals, freestanding community practices, patient advocacy organizations, and technology companies. Nearly 140 supporting organizations have endorsed ROCR, and no opposition has been identified.

This diverse support reflects broad agreement that ROCR represents a responsible, targeted reform that improves affordability, protects access, and strengthens cancer care delivery.

What Congress Should Do Now for Cancer Clinics and Patients

With total Medicare spending for radiation therapy less than the spending for just one cancer drug, radiation therapy remains one of the most cost-effective tools in cancer care, but only if Medicare payment policy sustains its delivery. Today, long standing payment flaws combined with the 2026 crisis are increasing the cost of delivering radiation therapy, forcing clinic closures, and pushing new burdens onto patients who already face cancer at one of the most vulnerable moments of their lives.

Therefore, ASTRO respectfully urges the Committee to:

1. **Advance the Radiation Oncology Case Rate Act as a targeted, financially responsible structural reform to stabilize payment and improve affordability.**
2. **Use committee oversight to examine how Medicare payment instability and recent code changes are affecting clinic viability and patient access.**

ROCR is the clear, consensus-backed solution. It stabilizes payment, aligns incentives with evidence-based care, improves consistency across care settings, protects access, supports continued innovation, improves affordability for clinics and patients, and is designed to save Medicare more than $200 million over ten years. As the Committee pursues Medicare physician payment reform, we urge the inclusion of the ROCR Act to improve payment policy and offset the costs of other essential reforms.

ASTRO appreciates the opportunity to submit this testimony and stands ready to serve as a technical resource to the Committee as it considers solutions to protect patient access and improve affordability.

PREMIER

Statement for the Record

Submitted by Premier Inc.

U.S. House Energy and Commerce Subcommittee on Health

"Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms"

May 20, 2026

Premier Inc. appreciates the opportunity to submit written comments for the record in response to the House Energy and Commerce Health Subcommittee's hearing titled "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms" on May 20, 2026. Premier Inc. applauds the commitment to address longstanding concerns around physician payment stability and administrative burden. We appreciate the thoughtful approach of seeking stakeholder input through this hearing on ways to improve the Medicare Access and CHIP Reauthorization Act (MACRA) and ensure future alternative payment models (APMs) deliver real improvements in cost and quality, while also ensuring successful scaling of innovations.

In our detailed recommendations below, Premier urges Congress to:

- Extend the advanced alternative payment model (APM) bonus for multiple years;
- Grant CMS authority to adjust the Qualifying APM Participant (QP) threshold;
- Direct CMS to address burdensome quality reporting and promoting interoperability requirements for accountable care organizations (ACOs);
- Strengthen the Medicare Shared Saving Program (MSSP);
- Require stronger oversight of fraud/waste/abuse and the impact to providers participating in total cost of care APMs;
- Set clear parameters for moving beyond testing to nationally scale successful models;
- Extend the Congressional Budget Office's scoring window to more accurately capture savings from preventive health initiatives;
- Eliminate cost sharing for attributed beneficiaries who require chronic care management to ease the financial burden;
- Establish flexibilities to develop rural-specific APMs; and
- Bolster physician payment by accounting for inflation.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,350 hospitals and approximately 325,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost.

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way healthcare is delivered nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. RECOMMENDATIONS FOR MACRA REFORM

Below is a comprehensive list of recommendations to reform MACRA and address the structural deficiencies that are slowing VBC expansion.

1. ***Extend the advanced APM bonus for multiple years.*** The Advanced APM bonus has been a crucial tool for clinicians in offsetting the costs associated with shifting to APM participation, such as investing in workflow improvements, digital health tools, care coordinators, data analytics and quality measurement systems. On average, ACOs spend between $1-2 million per year on these types of advanced care delivery tools. The Advanced APM bonus has also helped APMs expand services beyond traditional fee-for-service, such as funding wellness programs, reducing cost sharing for beneficiaries and improving patient care coordination.

   The Consolidated Appropriations Act, 2026 (H.R. 7148) provided a one-year reinstatement of the APM incentives for performance year 2026 (payment year 2028) of 3.1 percent. It is vitally important that Congress provide continued future funding of the advanced APM bonus for multiple years, as called for in the bipartisan Preserving Patient Access to Affordable Care Act (H.R. 786/S. 1460). A multi-year bonus will bolster degrading incentives and clearly signal Congress' commitment to strengthening these types of care models. The multi-year extension also recognizes the investments that providers must make when embarking into value-based care, which often requires a multi-year commitment.

2. ***Grant CMS authority to adjust the QP threshold.*** The increasingly high QP thresholds do not reflect the progress of the value-based care adoption. The COVID-19 pandemic made it harder for many providers to achieve the thresholds, as providers shifted resources and staff to pandemic response. Recent data from the Medicare Payment Advisory Commission (MedPAC) highlights that approximately 50 percent of Medicare beneficiaries are assigned to an APM and that includes both advanced and non-advanced APMs.[i] Therefore, achievement of statutory thresholds remains elusive for many providers, even those who are in an APM. Congress should grant CMS the authority to gradually increase or even decrease the payment and patient count QP thresholds based on current APM adoption rates and significantly change the threshold in the event of a public health emergency.

   Relatedly, the All-Payer Combination Option, considers the clinician's participation in advanced APMs both with Medicare and other payers. ***Congress should ask CMS to fast-track the All-Payer Combination Option to achieve QP status.*** Most providers rely solely on Medicare arrangements to meet the QP threshold because they have limited options for participating in Other Payer APMs, and the process for submitting data on participation is administratively complex and burdensome. Many Medicare Advantage plans offer APMs to their networked providers. CMS needs to develop a process to streamline requirements and credit providers for their participation in Medicare Advantage risk arrangements.

3. ***Direct CMS to address burdensome quality reporting and promoting interoperability requirements for ACOs.*** CMS needs to clearly differentiate quality reporting and promoting interoperability requirements among individual and group providers versus ACOs. Imposing MIPs requirements to APMs is not appropriate and has the effect of diminishing APM participation. Similarly, requiring ACOs to report all-payer data is comparable to requiring health plans to report on other payers' populations. Instead of building ACO quality reporting based on the structure used for individual clinicians, Premier strongly urges CMS to look at how quality reporting is conducted by health plans. For example, CMS could adopt a similar system used for HEDIS reporting, which combines data from multiple sources, including EHRs, clinical registries or health information exchanges (HIEs), case management systems and claims data. What CMS should not do is treat APM participants like they are MIPS clinicians.

   Premier applauds the House Energy and Commerce Subcommittee on Health for recently advancing the Health Care Efficiency Through Flexibility Act (H.R. 5347), signaling its commitment to policies aimed at improving and reducing quality reporting burden in value-based care programs. The bill would delay mandatory digital quality measures (dQM) for the Medicare Shared Savings Program through 2029, clarify

data completeness requirements, and establish a dQM pilot for selected ACOs for payment years 2028 - 2032. Premier urges the full committee to swiftly approve the bill.

4. ***Strengthen the Medicare Shared Saving Program.*** The MSSP is one of the largest and most successful value-based care programs. To ensure continued success, Congress should:

   - ***Eliminate the arbitrary high-low revenue distinction under MSSP to ensure all ACOs have the same opportunities to succeed under the program.*** Several years ago, CMS began varying MSSP policies based on an ACO's revenue status under the false premise that low-revenue ACOs outperform high-revenue ACOs and that low-revenue ACOs have less ability to control expenditures for beneficiaries. For example, high-revenue ACOs are forced to move to risk faster. A Premier analysis found that differences between high- and low-revenue ACOs are driven by other factors beyond ACO composition, including geographic location and the types of beneficiaries attributed to ACOs.[ii] This arbitrary distinction has led some ACOs to avoid partnering with certain provider types, such as hospitals or specialists. Eliminating the distinction will ensure that high performers are encouraged to participate regardless of provider type and will allow providers to more effectively collaborate in ways that best meet the needs of their patients.

   - ***Encourage participation in MSSP by restoring the percent of shared savings beginner participants receive to at least 50 percent.*** CMS reduced the potential for new ACOs to receive shared savings under its Pathways to Success reforms. As noted above, providers often must make significant investments to participate in value-based care. Restoring the rate to at least 50 percent recognizes the investments that ACOs must make to participate in MSSP and will further incentivize new ACOs to join.

   - ***Enjoin CMS to continue refining MSSP risk adjustment and financial benchmarking methodology.*** Recent experience with the accountable care prospective trend (ACPT) has shown that CMS' ACPT methodology continues to be flawed.[iii] Rather than maintaining an error-prone methodology, CMS could address the "ratchet effect" in its current financial benchmarking methodology through other means, such as less frequent rebasing of the financial baseline, adding back the full portion of shared savings to financial benchmarks (aka the "Prior Savings Adjustment"), in conjunction with simultaneous regional adjustments. At a minimum, if CMS decides to continue using the ACPT, then CMS should be required to adjust its projections when actual growth rates deviate widely from projected growth rates. This level of flexibility would also allow CMS to accommodate for unforeseen changes in the industry that impact healthcare spending. Additionally, rather than implementing multiple ACPTs depending on an ACO participants entry date, CMS should have a single growth rate projection for all participants, well in advance of the performance year.

     CMS also decided that an ACO's risk score cannot increase by more than 3 percent over its five-year agreement period. This policy may inadvertently result in ACOs choosing to drop certain high-risk and high-cost beneficiaries. Increasing the risk score cap to 5 percent and implementing a symmetrical floor on decreases in risk scores will ensure ACO benchmarks are sustainable and appropriately capture the cost of providing care to patients. Congress should work with CMS to address these methodological challenges will ensure that the MSSP continues to have intrinsic financial incentives for more participants to join the program.

   - ***Provide a glide path to capitation.*** Premier has long advocated for a model which allows an ACO to establish primary care capitation and bundled payments within the ACO. Congress should direct CMS to provide MSSP participants with a similar option which would allow them to reduce a certain percentage of fee-for-service payments in exchange for receiving a prospective population-based payment. CMS has employed similar methodologies in ACO REACH and Next Generation ACO, such as through the All-Inclusive Population-Based Payment. This option should be available to all ACOs under two-sided risk regardless of their MSSP track.

5. ***Stronger oversight of fraud/waste/abuse (f/w/a) and the impact to providers participating in total cost of care APMs.*** The most recent example of potentially fraudulent or abusive spending is the excessive growth in skin substitute spending, with CMS projecting expenditures exceeding $20 billion by 2026.[iv] APM participants are often at the forefront of detecting potential f/w/a due to being accountable for that spending as well. APM participants need additional protection from the financial impact of f/w/a. Congress should work with CMS on building additional protection for ACOs and providers in total cost of care arrangements. Policy areas to explore include bolstering CMS' significant, anomalous, and highly unusual (SAHS) billing policy, developing an outlier policy for anomalous spending, and standardizing processes for reconciling cases of f/w/a that are investigated after financial reconciliation settlements.

6. ***Amend Section 1115 of the Social Security Act to set additional parameters for moving beyond testing to nationally scale successful models.*** Over the past decade, the Innovation Center has launched more than 50 payments models. To date only three models have been certified for nationwide expansion and features from one model have been incorporated into MSSP.[v] There are several reasons why more models have not been expanded, including narrow expansion criteria that do not consider the full impact of models and the Administration's discretion over whether models are even considered for expansion. Providers invest significant resources to participate in model tests and additional transparency is needed for why certain models are discontinued and not considered for expansion. ***Congress should work with stakeholders to establish criteria for certifying and expanding models through a transparent rulemaking process***. As part of this, CMS should consider the broader impacts of model tests, including spillover effects of care redesign efforts on beneficiaries not included in models. Models should qualify for expansion based not only on their cost savings capabilities but also their ability to enhance patient quality of care or access to care. Additionally, ***CMS should be required to publish an annual report on its determinations of whether to expand models***, ***including actuarial analyses and supporting information for the determination***. Evaluations of models should control for variables such as model overlap to ensure accurate and informed decisions regarding expansion. Finally, it is critical that CMS include provider voices in the design, implementation and evaluation of models.

7. ***Extend the Congressional Budget Office's (CBO) scoring window to more accurately capture savings from preventive health initiatives.*** Premier encourages Congress to provide the CBO with the tools necessary to forecast the longer-term budgetary impacts of legislation to ensure policymakers are equipped with the best data when crafting legislative solutions, as called for in the bipartisan Preventive Health Savings Act (H.R. 4464). The way in which CBO currently scores legislation severely constrains the ability of policymakers to accurately assess legislation that would prevent chronic disease or other poor outcomes, thereby avoiding greater costs down the road. Research has demonstrated that certain expenditures for preventive interventions generate savings when considered in the long term, but those cost savings may not be apparent when assessing only the first ten years – those in the "scoring" window. Long-term benefits from current preventive health expenditures may not be fully reflected, if at all, in cost estimates from CBO. For example, MSSP ACOs had statistically significant higher performance for quality measures related to diabetes and blood pressure control; breast cancer and colorectal cancer screening; tobacco screening and smoking cessation; and depression screening and follow-up. The higher quality performance by ACOs underscores how this type of coordinated, whole-person care can reduce federal healthcare expenditures in future years by preventing more intensive and expensive care that would be required to treat severe illness or disability resulting in the absence of these early, preventive interventions. Yet, when evaluating the cost of legislation to extend the current financial incentives to healthcare providers that participate in these models, using CBO's current estimation process grossly understates the long-term value of this population-based approach to healthcare.

8. ***Eliminate cost sharing for attributed beneficiaries who require chronic care management to ease the financial burden and encourage beneficiaries to seek out care management.*** Several APMs are intentionally designed to provide beneficiaries with chronic diseases enhanced services, services that often come with additional out-of-pocket costs to patients. Removing the coinsurance payment requirement would facilitate more comprehensive management of chronic care conditions and improve the health of Medicare patients. Additionally, removing patient coinsurance will encourage patient participation and facilitate greater care coordination for vulnerable populations.

III. RECOMMENDATIONS FOR RURAL-SPECIFIC APMS

Rural providers face unique challenges that inhibit their ability to participate in two-sided risk APMs, including financial constraints, lower patient volumes and workforce limitations. Traditionally, rural providers operate on tight margins, which limits their ability to absorb downside risk, discounts or other payment cuts. Moreover, many rural hospitals are reimbursed through cost-based payments that can be unpredictable year-over-year, making it difficult to establish annual financial benchmarks. Rural providers also have lower patient volumes compared to their urban and suburban counterparts and a higher prevalence of chronic conditions. That said, it is important to recognize that there are variations within the definition of rural – for example, rural in Maine may have very different patient volumes and patient demographics than rural in Mississippi.

Premier urges Congress to consider the following recommendations to support the design of rural-specific payment models:

- ***Redefine success for rural APMs.*** In lieu of focusing on cost savings, rural APMs should focus primarily on improving quality and/or access, which will require changes to Section 1115 criteria for model expansion and CMS Office of Actuary certification. It may not be reasonable for rural providers to participate in two-sided risk models if it could result in service line closures and harm access to care. Instead, CMS should include rural-specific metrics such as maintaining access to care in rural communities. Additionally, CMS should reward utilization of preventative services (e.g., annual wellness visits, preventive screenings such as breast and colon cancer) and improvements in access to nutritious foods.

- ***Apply minimal level of risk to qualify as an Advanced APM*.** MACRA requires a "nominal" level of risk for an APM to qualify as an Advanced APM. CMS should apply the lowest level of risk (<1 percent) to meet this requirement so that rural providers may benefit from the enhanced conversion factor. However, CMS should not include the additional part B revenue in financial benchmarks but treat it similarly to the Advanced APM bonus. If the enhanced revenue is included in financial benchmarks, then it may potentially conflate the ACO's financial targets relative to the region, assuming that regionally other providers are not receiving the enhanced conversion factor.

- ***Develop a rural-specific, risk-adjusted benchmark*.** Due to the unpredictable fluctuations from cost-based reimbursement, CMS should use a three-year period for the financial benchmark with increasing relative weight for more recent years. Secondly, CMS should leverage the concurrent HCC model from ACO REACH, or the rolling HCC methodology utilized in ACO Primary Care Flex to risk-adjust the benchmark. Historical utilization may not adequately capture the risks of a rural population since patients may put off care due to access challenges.

- ***Permit flexibility in ACO participant list*.** CMS should allow ACO participants to be defined at the CMS Certification Number (CCN) level rather than the Tax Identification Number (TIN) level. The reason for this is that a TIN may include both rural and non-rural facilities. The current MSSP TIN structure does not allow for carving out rural hospitals.

- ***Provide additional waivers and incentives*.** Rural providers do not have access to the same level of resources as everyone else. They need additional investments, for example, through upfront investment or enhanced capitated payments to create bridges to services that may not be available locally such as maternal health, behavioral health, and substance use disorder treatment. Additional telehealth waivers could also help fill in those gaps, as well as investments in targeted chronic disease programs (e.g., enhanced Medicare Diabetes Prevention Program payments).

IV. RECOMMENDATIONS FOR MIPS REFORM

A number of organizations, including the MedPAC has identified a need for physician payment rates that account for rising inflation.[vi] The unprecedented growth in inflation since the COVID-19 pandemic could not be anticipated by Congress in 2015 when it kept the physician conversion factor until 2026, after which it would rise at a fixed rate for two different conversion factors that are dependent on QP status. Consequently, Congress has had to intervene over the years with one-time adjustments, including a +2.5 percent adjustment in the most recent One Big Beautiful Bill Act. Any reform to MIPS should also address physician payments. Premier urges Congress to consider the following:

- ***Bolster physician payment by accounting for inflation.*** Any changes to MIPS and/or the Physician Fee Schedule needs to incorporate inflation in the calculation of Medicare physician payments. Physician fee rates over the past several years have not kept pace with inflation and the rising costs of providing healthcare. Left unchecked, this may pose a serious access issue to Medicare beneficiaries if providers drop their Medicare patients in favor of commercial patients or concierge business models. MedPAC's June 2025 report offered one suggestion, which is to tie conversion factor updates to the Medicare Economic Index, but many other proposals exist.[vii]

V. CONCLUSION

Premier appreciates the opportunity to provide feedback on reforming MACRA and strengthening value-based care. We look forward to working with you to design sustainable incentives that improve patient outcomes and reduce costs. For additional information, please contact John Knapp, Vice President of Advocacy at john_knapp@premierinc.com or 240-839-0739.

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[i] https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_SEC.pdf
[ii] https://premierinc.com/newsroom/blog/pinc-ai-analysis-hospital-led-acos-perform-as-well-as-physician-led-models
[iii] https://www.milliman.com/en/insight/predictability-accuracy-mssp-benchmarks-acpt
[iv] https://www.healthaffairs.org/content/forefront/three-ways-cmmi-applying-evidence-protect-patients-providers-and-taxpayers
[v] https://www.cms.gov/priorities/innovation/data-and-reports/2022/rtc-2022
[vi] https://www.medpac.gov/document/june-2024-report-to-the-congress-medicare-and-the-health-care-delivery-system/#
[vii] https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf

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Lynn M. Schuchter, MD, FASCO
Chair of the Board
Association for Clinical Oncology

Statement prepared for:
United States House Committee on Energy & Commerce
Subcommittee on Health

Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms
May 20, 2026

The Association for Clinical Oncology (ASCO) is pleased to submit this statement for the record of the hearing entitled, "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms." ASCO appreciates that the Subcommittee is holding this hearing to identify ways to ensure that Medicare reimbursement enables financial stability for physicians and protects essential cancer care access for patients.

ASCO is the world's leading medical oncology professional organization and represents over 50,000 clinical oncologists, researchers, and other professionals who treat patients with cancer. ASCO works to ensure that all individuals with cancer have access to high quality care, that cancer delivery systems support optimal cancer care, and that our nation supports robust federal funding for research.

ASCO supported the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) as a replacement to the flawed Sustainable Growth Rate (SGR) formula for Medicare physician reimbursement. Since its enactment, ASCO has provided extensive education to its members as well as significant input to the Centers for Medicare and Medicaid Services (CMS) around necessary refinements to the program to ensure its efficacy for physicians and for the Medicare beneficiaries they serve. Unfortunately, there is still ongoing financial instability within the Medicare payment system, and physicians face the same uncertainty MACRA was intended to address.

We are encouraged by the Subcommittee's interest in addressing current challenges and look forward to collaborating on ways to guarantee sustainability in the Medicare payment system. ASCO offers to be an ongoing resource as the Subcommittee evaluates the financial stability and patient impact of the Medicare physician payment system, MACRA's effectiveness, and the continued transition to a value-based payment system.

Below are areas of improvement we believe are vital to achieving high-value, high-quality care for all patients with cancer.

1. **The Medicare Physician Fee Schedule and Conversion Factor Updates**

Congress must address the lack of sufficient payments within the Medicare Physician Fee Schedule (MPFS) by implementing predictable, inflation-based increases to the conversion factor (CF). The MPFS is the only payment system within Medicare without an annual inflationary update; in fact, data from the American Medical Association shows that, when adjusted for inflation in practice costs, physicians paid under the MPFS have seen decreases in payment of up to 33% over the last two decades.

In repealing the SGR, MACRA specified a 0% update to the MPFS CF for a period of six years, followed by a 0.25% annual increase for Merit Based Incentive Payments System (MIPS) participants and a 0.75% annual increase for Advanced Alternative Payment Model (APM) participants thereafter. In practice, however, the thresholds for qualifying for these increases have been challenging for physicians to meet, particularly in small and rural practices. Even those providers who meet the thresholds find that positive payment adjustments do not fully cover the costs of the care they are providing. Therefore, predictable, annual CF updates are needed to provide the financial stability physicians need to continue serving patients in community settings.

While Congress or CMS have provided temporary relief to physician payment cuts on several occasions, – most recently, through a one-time 2.5% increase as part of the Calendar Year (CY) 2026 PFS – these increases are often offset by other changes to the MPFS. Physician practices cannot continue to absorb increasing costs while their payment rates decline, especially as many healthcare providers are small business owners. They must contend with significant economic factors that determine their ability to provide care to Medicare beneficiaries. ASCO advocates for a permanent, inflation-based CF update equal to 100% of the Medicare Economic Index (MEI), as proposed in H.R. 6160, the *Strengthening Medicare for Patients and Providers Act*.

Inflationary increases will help providers keep up with rising healthcare costs. Failure of the MPFS to keep up with increasing labor, supplies, rent, and other practice expenses influences a growing site-of-service shift from independent physician practices to off-campus outpatient hospital departments paid for by the Outpatient Prospective Payment System (OPPS). Rather than addressing the lack of sufficient payment under the MPFS, Congress directed CMS to reduce payments to new off-campus outpatient hospital departments, thereby encouraging further shifts into on-campus departments. Instead of encouraging value-based care, this consolidation results in reduced beneficiary access to community-based healthcare services. Congress must ensure that future payment updates within the MPFS are sufficient to sustain beneficiary access to community-based physician care.

Finally, ASCO encourages Congress to limit year-to-year variance of the CF to provide greater stability for the Medicare physician payment system by removing relatively large and abrupt

changes in conversion factor calculations. ASCO notes that these limits must be implemented in a way that is not offset by other reforms. For example, under the CY 2026 PFS, oncology providers will see much of the CF increase offset by reductions to work relative value units (RVUs) – effectively financing part of the update through cuts elsewhere. The largest single-year adjustment is the temporary +2.5% increase authorized by Congress, which will expire at year's end and, without further legislative action, result in a significant reduction in CY 2027 – repeating the disruptive volatility experienced in 2025 when short-term congressional relief expired.

2. **Merit-based Incentive Payment System**

The current MIPS framework has a disproportionate, negative impact on small and solo practices. For example, in the 2023 performance year, small (13.07%) and solo (28.77%) practices were more likely to receive the maximum penalty (-9%) than MIPS clinicians overall.[1] A temporary reduction in MIPS adjustments would prevent future practice closures and ensure Medicare's value-based initiatives do not inadvertently dismantle the healthcare infrastructure in underserved communities.

Furthermore, Congress should re-examine the budget neutrality and exceptional performance bonus under MIPS. When the MIPS track of the Quality Payment Program (QPP) was originally envisioned, it was thought that a budget neutral system would provide rewards to high performers, while penalizing low performers. Experience has shown us that small and rural practices disproportionately bear the burden of growing penalties, which in the aggregate are far too small to result in any meaningful distribution to higher performers. ASCO supports key elements of H.R. 8622, the *Medicare Physician Data-driven Performance Payment System Act of 2026*, that would eliminate the MIPS win-lose style payment adjustments and instead link physicians' MIPS performance to a portion of their annual payment update (e.g., 0.25% under MACRA or the percentage increase in MEI).

3. **Budget Neutrality Threshold**

ASCO is supportive of updates to the overall budget neutrality threshold and encourages legislation that would require indexing the threshold to MEI every five years; such a proposal is included in H.R. 8163, the *Provider Reimbursement Stability Act*. An update to the budget neutrality threshold will allow greater flexibility in determining pricing and policy changes for services without triggering across-the-board cuts. This change will improve the financial viability of physician practices, particularly those in rural and underserved areas.

4. **Advanced Alternative Payment Models**

Oncology clinicians have primarily participated in two APMs, the Medicare Shared Savings Program (MSSP) and the Enhancing Oncology Model (and formerly the Oncology Care Model (OCM)). ASCO is encouraged by the development of these models and CMS's movement

[1] Resource: QPP

towards value-based care. To further promote progress in this positive direction, Congress should extend and improve access to incentive payments for participation in eligible alternative payment models.

MACRA provided for a time-limited, annual payment incentive to Qualifying APM Participants (QPs) equal to 5% of estimated aggregate payment amounts for covered professional services. The incentive payment was intended to encourage participation in APMs and has proven to be critical in assisting physicians in developing the infrastructure necessary for the transition to value-based payment models. ASCO commends Congress for its decision to restore incentive payments at a rate of 3.1% for the 2026 performance year in the Consolidated Appropriations Act of 2026. While we appreciate Congress' efforts to ensure that providers are able to successfully participate in value-based payment models in the short-term, we urge them to provide longer-term solutions to address the incentive gap we are nearing. Specifically, Congress should extend the incentive payment until at least 2030 as a short-term solution and consider longer-term solutions to ensure ongoing stability.

Further, to qualify for the APM incentive, physicians must meet either the Medicare Payment Threshold Option or Medicare Patient Threshold Option. These thresholds are meant to ensure that physicians meaningfully participate in alternative payment models. However, many specialty physicians, including oncologists, find it difficult to qualify under the currently specified thresholds. According to CMS's reports on payment year 2023 (the most recent year for which data is available), the average payment threshold score for MSSP was 46.42 and 53 for the OCM.[2] Under current thresholds, clinicians cannot reach QP status. ASCO supports maintaining the current thresholds to prevent clinicians from falling short of reaching the target thresholds.

Conclusion

Thank you for your commitment to improving the Medicare program. ASCO stands ready to serve as a resource as the Subcommittee continues this much needed dialogue around reforms to the physician reimbursement system. Please contact Maureen Szemborski at Maureen.Szemborski@asco.org with any questions.

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[2] APM Incentive Payments for 2023

AMGA MACRA and Value-Based Care Task Force Recommendations

AMGA's six pillars to improve care delivery and continue the transition to high-value care

As the U.S. healthcare system stands at a pivotal juncture, the imperative to reassess and refine the future of healthcare financing to support modern care delivery and practices has never been more pressing. Central to this evolution are group practices and integrated systems of care, which are uniquely positioned to lead the transformation toward a more coordinated, efficient, and patient-centered model. These organizations have demonstrated the capacity to deliver high-quality care while managing costs, making them essential players in the journey toward value-based care (high-value care).

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, AMGA is the national voice promoting awareness of its members' recognized excellence in the delivery of coordinated, high-quality, high-value care. There are more than 177,000 physicians practicing in AMGA member organizations, delivering care to more than one in three Americans. AMGA is uniquely positioned to offer policy recommendations on programmatic improvements to Medicare.

Recognizing the approaching 10-year anniversary of the Medicare Access and CHIP Reauthorization Act (MACRA), AMGA established the **MACRA and Value-Based Care Task Force** in 2023 to build on the successes of the law, while also recognizing the potential for improvements. This initiative responds to congressional inquiries about ensuring that Medicare appropriately reimburses professional services under Part B and enhances the viability and sustainability of high-value care. The Task Force comprises members from some of the nation's leading multispecialty group practices and integrated care systems, all committed to transforming healthcare delivery in the United States.

The Task Force began its work by identifying policies and regulations within the Medicare reimbursement system that hinder the ability of AMGA members to provide optimal care. While MACRA aimed to shift Medicare from a fee-for-service model to one that rewards value, its execution has revealed challenges. These include complexities in the Merit-Based Incentive Payment System (MIPS), limited participation in Advanced Alternative Payment

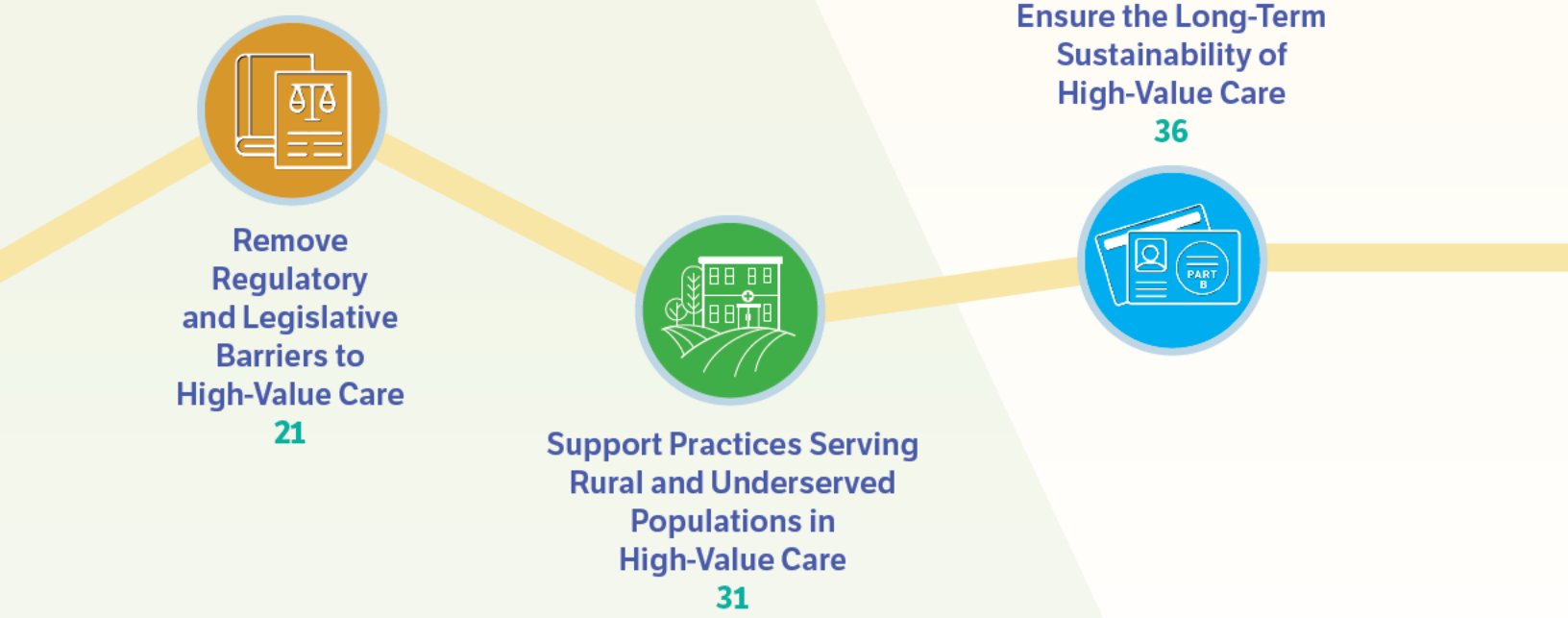
Recommendations

Models (APMs), and the need for more robust support for small, rural, and underserved practices. Informed by their experiences delivering care under MACRA's reimbursement and regulatory framework, the Task Force examined all aspects of the care delivery reimbursement model.

Through comprehensive analysis, the Task Force identified six foundational pillars essential for reforming MACRA and advancing high-value care:

1. **Enhance Patient Engagement**: Empower patients to take an active role in their healthcare decisions.
2. **Improve Health Outcomes**: Address disparities to ensure all populations receive high-quality care.
3. **Protect Patient Dignity at End of Life**: Promote compassionate care that respects patient preferences.
4. **Remove Regulatory and Statutory Barriers**: Reduce administrative burdens that impede care delivery.
5. **Support Practices Serving Rural and Underserved Populations**: Ensure equitable resources and support for all providers.
6. **Ensure the Long-Term Sustainability of High-Value Care**: Establish a payment model that ensures long-term viability for providers.

This report presents the Task Force's policy recommendations for each pillar, aiming to guide policymakers in reauthorizing MACRA and shaping a simple and sustainable healthcare system that supports the ability of AMGA members to deliver high-value care. By removing regulatory and statutory barriers and enabling patients to engage with their provider teams on their treatment plans and goals, the Task Force's recommendations are designed to meet the needs of all patients across the country, regardless of location and income, by reforming Medicare's reimbursement system. By focusing on the strengths of group practices and integrated care systems, we can pave the way for a future in which high-quality, patient-centered care is accessible to all.



Enhance Patient Engagement in High-Value Care

AMGA Goal

Incentivize and empower patients to make informed decisions about their healthcare by designing care delivery and financing systems that eliminate access barriers and promote preventive care.

AMGA members recognize that meaningful patient engagement is critical to improving health outcomes, enhancing patient satisfaction, and increasing overall healthcare efficiency. Effective patient engagement strategies are essential to encouraging patients to take an active role in their health, adhere to treatment plans, and adopt healthier lifestyles.

To achieve this goal, AMGA recommends that Congress:

- **Offer financial incentives to Medicare patients for healthy behaviors**: Provide modest financial incentives, such as premium reductions or rewards, for participating in preventive health activities such as exercise programs or dietary improvements. These incentives can drive sustained behavior change, improve clinical outcomes, and reduce the long-term burden of chronic disease.
- **Waive Medicare cost-sharing requirements for chronic care and chronic care management services**: Eliminate out-of-pocket costs for Medicare beneficiaries with chronic conditions. Removing financial barriers would increase engagement in care and improve disease management. This would especially benefit low-income seniors, reducing disparities in access and care outcomes.
- **Permanently remove geographic and originating site restrictions for telehealth**: Permanently codify the Medicare waiver of geographic and originating site limitations to ensure broad, equitable access to telehealth services—especially in rural and underserved communities. Continued virtual access promotes care continuity and supports patients with mobility or transportation challenges.

Dr. Scott Hines on the Importance of Patient Engagement

Patient engagement is essential, not just for empowering individuals to take charge of their health, but also for building stronger relationships between patients and providers. When patients are informed and actively involved in their care, outcomes improve, providers can deliver more personalized treatment, and the entire healthcare system becomes more efficient and sustainable.

It helps reduce unnecessary hospital visits, improves adherence to treatment plans, and ultimately leads to better use of healthcare resources.

Engaged patients are partners in care—and that collaboration drives real, lasting health improvements. Financial incentives and eliminating obstacles to care, including cost, can further enhance patient engagement by making healthcare more accessible and motivating individuals to participate actively in their own care.

— **Scott Hines, MD**, *Chief Quality Officer, Crystal Run Healthcare*

- **Fund digital health navigators to bridge the digital divide**: Reimburse medical groups and health systems for employing digital health navigators who assist patients with technology. These navigators can help patients use telehealth platforms, understand health data, and engage with remote monitoring tools. Funding for navigators would ensure technology is an enabler, not a barrier.
- **Mandate data sharing from commercial payers to providers**: Require commercial insurers to provide timely access to claims data. Improved data sharing enables providers to better coordinate care, close care gaps, and manage population health. This would align payers and providers around shared value-based goals.

Offer financial incentives to Medicare patients for healthy behaviors

Affordability remains one of the most significant barriers to healthcare access in the United States. High copayments, out-of-pocket costs, and the absence of financial incentives deter patients from seeking care or following through on treatment plans, ultimately leading to poorer health outcomes and higher systemwide costs. Aligning financial incentives to support prevention and chronic disease management is essential to improving outcomes and reducing avoidable high-cost utilization.

Payment and care delivery structures can either support or deter patient engagement. Cost-sharing requirements and the fear of unexpected bills disproportionately affect patients with chronic or complex conditions. According to a study published in the *Journal of Internal Medicine*, 37.7% of participants cited concerns about cost as a reason for avoiding care.[1] To overcome these barriers, policymakers must implement payment and care delivery reforms that align with patient-centered care and promote sustained engagement, the hallmarks of high-value care.

Currently, financial incentives for patient engagement in traditional Medicare are limited and largely indirect, except in the Medicare Shared Savings Program (MSSP). These MSSP incentives generally offer direct financial rewards capped at $20 for primary care services.[2] By contrast, Medicare Advantage (MA) plans and private insurers commonly offer tangible rewards to patients, including gift cards, reduced premiums, or waived copays for participating in wellness-focused activities, such as physical exams, vaccination programs, or even gym memberships.

To align traditional Medicare with the engagement structures seen in MA and commercial insurance, Congress should authorize direct financial incentives for Medicare beneficiaries who take proactive steps to improve their health. These incentives could mirror existing MA incentives by including lower cost-sharing, reduced premiums, or rewards for completing preventive screenings, participating in chronic disease management programs, or adopting healthy lifestyle changes.

Waive Medicare cost-sharing requirements for chronic care and chronic care management services

Under traditional Medicare, beneficiaries are responsible for deductibles, coinsurance, and copayments for most services. While some preventive services—such as screenings for cancer, diabetes, and heart disease—are exempt from cost-sharing, patients still incur costs for necessary follow-up tests and ongoing care.

These costs can be particularly burdensome for individuals with chronic conditions or complex healthcare needs. Medicare Part B's structure stands in contrast to the private insurance market, where insurers more frequently employ financial incentives such as reduced premiums and lower cost-sharing to promote patient engagement.

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1. Taber JM, Leyva B, Persoskie A. Why do people avoid medical care? A qualitative study using national data. J Gen Intern Med. 2015 Mar;30(3):290-7. doi: 10.1007/s11606-014-3089-1. Epub 2014 Nov 12. PMID: 25387439; PMCID: PMC4351276
2. https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/bip-guidance.pdf

AMGA providers report that patient engagement improves when cost-sharing requirements do not serve as an obstacle to care. Reducing financial barriers can increase uptake of preventive services, follow-up visits, and chronic disease management —key elements of effective care delivery.

The U.S. Preventive Services Task Force (USPSTF) plays a vital role in guiding preventive care through evidence-based recommendations on screenings, counseling, and services. Under the Affordable Care Act (ACA), private health plans are required to cover USPSTF-recommended preventive services with no cost-sharing.[3] However, the USPSTF's scope focuses primarily on early detection and risk reduction, rather than ongoing management and treatment of chronic diseases.

While early diagnosis is essential, chronic conditions such as diabetes, hypertension, and heart disease require continuous, coordinated care. Effectively addressing chronic disease demands broader strategies that include coordinated care teams, patient education, lifestyle support, and access to affordable treatment.

AMGA views the USPSTF recommendations as a valuable foundation, but emphasizes the need for policies and care models that prioritize long-term disease management. AMGA recommends eliminating cost-sharing for chronic disease management services, including regular screenings, follow-up appointments, and preventive interventions. By reducing costs for patients with chronic conditions, we can increase engagement and reduce avoidable, high-cost health events.

Medicare reimburses clinicians for non-face-to-face chronic care management (CCM) under a separately billable code in the Medicare Physician Fee Schedule (MPFS) for beneficiaries with two or more chronic conditions. However, any value a beneficiary receives is offset by a 20% coinsurance obligation for patients, establishing an unexpected and unavoidable barrier to care.

> *"Patients who have been receiving care management services for free are reluctant to start paying. Patients also are apprehensive about their copayment for this program and are reluctant to enroll."*
>
> — **Beth Averbeck, MD, FACP,** *Senior Medical Director, Primary Care, HealthPartners*

Out-of-pocket expenses often discourage patients from consenting to CCM services. By removing cost-sharing barriers, Congress would incentivize patients to participate in regular care coordination, medication management, and preventive interventions—reducing the risk of costly complications and hospitalizations. Eliminating CCM cost-sharing also aligns with high-value care principles that favor proactive management over reactive treatment. AMGA previously endorsed the Chronic Care Management Improvement Act of 2023, which would waive cost-sharing for CCM services.[4]

Permanently remove geographic and originating site restrictions for telehealth

Technological advancements offer powerful opportunities for patients to engage with healthcare providers from the comfort of their homes. As noted in the "Improving Health Outcomes through High-Value Care" section of this report, transportation remains a major barrier to care—especially for those in rural or underserved areas, individuals with limited mobility, or people without reliable vehicle access. Transportation-related challenges often lead to missed appointments, increased emergency department use, and higher out-of-pocket costs. These financial and logistical burdens can be a disincentive for patients from seeking care altogether.

3. Sec. 2713 of the Affordable Care Act

4. https://www.amga.org/about-amga/newsroom/press-releases/2024/april/amga-endorses-chronic-care-management-reform

Telehealth and digital health tools can help bridge these gaps by improving accessibility and reducing travel-related costs. Telehealth allows patients to connect with healthcare providers through video calls, phone consultations, or messaging apps—facilitating continuity of care without the need for physical visits.

For patients in rural communities, telehealth can connect them with specialists or healthcare providers otherwise unavailable locally. This access is vital for individuals who would otherwise need to travel long distances for specialized care.

Fund digital health navigators to bridge the digital divide

To enhance patient access and engagement in digital healthcare, reimbursing medical groups and health systems for employing digital health navigators is essential. These navigators assist patients in utilizing telehealth platforms, understanding health data, and engaging with remote monitoring tools, ensuring that technology serves as an enabler rather than a barrier. By providing guidance on digital tools, navigators help patients overcome challenges related to digital literacy and connectivity, particularly in underserved communities. This support not only facilitates the effective use of telehealth services, but also promotes equitable access to care.

Digital health tools, including wearable devices and mobile health applications, also enable remote monitoring of vital health metrics such as blood pressure, glucose levels, and heart rate. This continuous monitoring allows for early detection of health issues and timely interventions, reducing the need for frequent in-person visits and associated costs. Remote Patient Monitoring (RPM) further enhances chronic disease management by providing real-time data to healthcare providers, supporting better treatment adherence, reducing hospitalizations, and improving care coordination. Integrating digital health navigators into care teams, alongside the adoption of RPM technologies, can significantly improve clinical outcomes and make healthcare more affordable and accessible for all patients.

Mandate data sharing from commercial payers to providers

To deliver high-quality, coordinated care, providers need access to commercial claims data. These data—submitted by insurers—offer a comprehensive view of a patient's healthcare utilization, treatments, and cost patterns across settings. Unlike electronic health records, which reflect only the care delivered by a specific

Dr. Eric Wallace's Testimony on Rural Healthcare Access Challenges in Demopolis, AL, before the Senate Finance Committee

In many cases, telehealth provides better care than the previous in-person alternative. Previously, if a dialysis patient arrived at Demopolis with life-threatening high potassium, they were given a medicine to remove the potassium through the stool.

The patient would then be put in an ambulance and transported to the nearest dialysis-ready hospital, which would take at least 90 minutes. The ambulance had to wait at the hospital while the patient waited on a bed, and finally, around 8 to 12 hours later, the patient would be dialyzed. It was the best we could do at the time. But this was a disservice to the patient.

An ambulance is used each time a patient is transferred to a larger center from Demopolis. Marengo County, Alabama, only has three ambulances, so if two patients were being transferred due to a lack of local services, that leaves only one ambulance to cover the whole county. With telehealth, we are able to do a nephrology consult on the patient in Demopolis; the rural hospital keeps the patient, and we are able to start dialysis within one hour of the patient's arrival.

— **Eric Wallace, MD**, *Professor of Medicine in the Division of Nephrology and Medical Director, UAB Health System Telehealth Program*

provider, claims data capture services performed elsewhere, such as preventative screenings, diagnostic tests, and emergency care. AMGA's annual risk survey consistently identifies lack of access to claims data as an obstacle to high-value care.[5]

Incorporating these additional data would offer a more complete, "real-time" picture of the patient's health journey. This would reduce unnecessary procedures, minimize duplicative testing, and lower the overall cost of care.

Claims data also enable providers to go beyond episodic care and manage care holistically. They reveal past diagnoses, medications, and interactions with other healthcare professionals—critical for managing patients with complex or chronic conditions. With this full picture, providers can identify care gaps, such as missed preventive screenings, and foster shared decision making with both patients and clinicians to reduce the risk of conflicting treatments or adverse medication interactions.

Beyond individual care, claims data strengthen population health management and support high-value care models. They enable providers to analyze trends, predict risks, and allocate resources effectively. This data-driven approach improves patient outcomes while supporting systemwide efficiency and cost containment.

Benefits of Remote Patient Monitoring

"Advocate Hospital at Home enables patients to receive at home, hospital-level care with hospital-level monitoring overseen by nurses. For the appropriate patients, this allows quicker recovery in a familiar setting surrounded by family."

— **Elisabeth Stambaugh, MD, MMM**, *Chief Medical Officer, Wake Forest Health Network, Atrium Health Wake Forest Baptist*

Conclusion

Fostering meaningful patient engagement is key to improving patient outcomes and transitioning to a high-value care system. AMGA believes this requires a comprehensive strategy built around aligning financial incentives and eliminating structural barriers. Key challenges—such as health literacy disparities, lack of data transparency, and unequal access to care—must be addressed.

Congress must recognize how financial burdens, confusing billing practices, and restricted access to information hinder patients from fully engaging in their care. By promoting financial incentives, expanding digital access, improving transparency, and enhancing patient education, lawmakers can modernize the healthcare system and empower patients to become active participants in their health.

5. 2025 AMGA Issue Brief on Access to Claims Data available at www.amga.org/getmedia/817d6dc2-bc6a-4179-a18e-e052935bfdbd/2025-access-to-claims-data-issue-brief.pdf

Improve Health Outcomes Through High-Value Care

AMGA Goal

Improve health outcomes through a multifaceted approach that empowers patients, eliminates barriers to access, promotes coordinated and patient-centric care, and supports high-value care models. Reforms must focus on systematic improvements that create improved health outcomes, rather than on separate and distinct efforts.

AMGA strongly supports efforts to help providers address our nation's chronic disease crisis by targeting disparities that disproportionately affect health outcomes across various populations and geographic locations. With a comprehensive approach that embeds appropriate goals and incentives into care models and provides greater integration of necessary systems, we can work to ensure healthcare is accessible, effective, and tailored to meet the needs of every beneficiary. By reducing disparities driven by factors including race, ethnicity, socioeconomic status, and geographic location, we can make America healthier, increasing life expectancy while reducing healthcare costs.

Healthcare providers play a critical role in addressing chronic disease and its associated poor health outcomes, but it is essential for policymakers to recognize healthcare systems cannot solve this crisis alone. Within the healthcare industry, it is widely recognized that up to 80% of health outcomes are linked to issues outside the control of healthcare providers and require broader societal interventions.[1] The healthcare system is currently tasked with treating illnesses and managing health conditions, but social drivers of health—such as housing, education, food security, transportation, and economic stability—heavily influence health outcomes. For example, a patient with diabetes may receive high-quality medical care, but lack access to affordable, nutritious food or safe spaces for physical activity. Even if such patients receive optimal medical care, their health might still deteriorate due to their underlying environmental circumstances. Expecting healthcare providers to solve systemic issues without addressing underlying

AMGA: Improving Care for All

AMGA Foundation launched an effort to address atherosclerotic cardiovascular disease (ASCVD) care.

The ASCVD Best Practices Learning Collaborative joins a long list of initiatives by AMGA Foundation to help medical groups improve the care of patients with chronic conditions and preventable illnesses.

Participants describe challenges they have faced and overcome, ways to share and scale solutions, and tactics for developing potential innovations.

By compiling evidence of best practices, these initiatives seek to establish standards for optimal care.

AMGA reviewed the data for each participating group and found women with ASCVD were 10-15% less likely to be getting appropriate care for their condition, namely a prescription for a statin.

1. Magnan, S. 2017. Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC.

socioeconomic drivers places an unrealistic burden on the system and its workforce. More importantly, these efforts are unsustainable and ultimately unsuccessful.

Despite these challenges, AMGA represents thousands of providers who understand the vital and instrumental role our healthcare system plays in addressing these disparities and dismantling the chronic disease epidemic.

To help the provider community best serve the American public, AMGA recommends that Congress integrate health outcomes into policy decisions, program design, and healthcare delivery models by pursuing the following:

- **Support providers' ability to address larger societal challenges as an aspect of high-value care**: Empowering healthcare providers to tackle broader societal issues—such as housing instability, food insecurity, and transportation barriers—can lead to more comprehensive and effective patient care. By integrating social drivers of health into care plans, providers can improve health outcomes and reduce long-term healthcare costs.
- **Standardize metrics, technology, and payment models to promote optimal outcomes**: Implementing uniform quality metrics, interoperable technologies, and consistent payment structures enables healthcare systems to better measure performance, enhance care coordination, and incentivize high-value care.
- **Expand community resources to address barriers to care**: Investing in community-based services—such as mobile clinics, telehealth access points, and health education programs—can mitigate barriers like geographic isolation, lack of transportation, and limited health literacy. Enhancing these resources ensures all populations can access high-quality care.

Support providers' ability to address larger societal challenges as an aspect of high-value care

High-value care encourages providers to adopt interventions to support patient health holistically, considering both the medical and nonmedical needs that impact well-being. To further these goals, targeted policies and reimbursement structures are essential to ensure patients receive the specific attention and care they need based on their individual circumstances. This can be achieved through appropriate payment adjustments, tracking population health outcomes, and offering financial incentives to patients.

Payment adjustments that account for patient characteristics, such as socioeconomic status or geographic location, ensure providers have the resources they need to care for all communities and provide access to high-quality care. Higher reimbursement rates for addressing disparities or managing complex care needs support the ability of healthcare providers to treat patients' immediate care needs, while also collaborating with patient navigators and community-based organizations to manage non-healthcare needs that significantly impact a patient's overall well-being. Federal policy should emphasize performance metrics that track population health outcomes. Timely and relevant data can empower providers to provide targeted interventions that address gaps in care. In addition, financial incentives for patients to engage and maintain their health help patients adopt healthier behaviors, drive appropriate engagement with providers supporting their health, and reduce barriers to care.

High-value care can serve as a powerful tool to improve health outcomes by aligning financial incentives with improved patient outcomes. When policymakers create payment structures that empower providers to deliver holistic, person-centered care and allow flexibility in treatment approaches, providers will be better equipped to address social drivers of health and improve health outcomes.

Standardize metrics, technology, and payment models to promote optimal outcomes

The shift to high-value care is hindered by critical gaps in infrastructure and data integration. Without the appropriate foundation, how can we expect the system to remain stable or improve?

The absence of a robust, standardized data infrastructure limits providers' ability to capture, analyze, and act on essential information. Inconsistent data systems hinder the ability to monitor progress, identify disparities, and ensure care delivery is delivered as efficiently and effectively as possible. Without integrated technology and comprehensive data collection, high-value care's potential to improve outcomes remains untapped.

Compounding this issue is the lack of standardized metrics and comprehensive reporting mechanisms at the state and national levels. While high-value care models aim to address disparities, the absence of transparent, standardized metrics makes it difficult to assess whether interventions are effective and identify where gaps in care still exist. According to a 2024 NAACOS white paper, ACOs frequently cite difficulties integrating disparate electronic health record (EHR) systems and aligning data from multiple payers as a core barrier to effectively using data to drive high-value care.[2]

Potential solutions to modernize our data infrastructure include:

- Ensuring adequate federal funding for health IT systems, including mandated upgrades necessary to comply with new or revised regulatory requirements, as required by the 21st Century Cures Act (Cures Act) and the Health Information Technology for Economic and Clinical Health (HITECH) Act
- Supporting interoperability standards across payers and providers
- Establishing comprehensive health metrics to enable healthcare organizations to compare health outcomes across national benchmarks

By enhancing systems that can track and measure health outcomes, healthcare providers will gain actionable insights, enabling more informed decision making to better target interventions and address disparities.

Expand community resources to address barriers to care

Healthcare providers cannot drive change alone. To meet patients where they are, especially in underserved and historically marginalized communities, systems must be empowered to

Dr. Paul Pritchard on the Importance of Addressing the Needs of the Underserved

Through initiatives like the Colorectal Cancer Screening Best Practices Learning Collaborative led by AMGA, we have consistently integrated goals into our quality metrics to ensure that all patient populations receive appropriate preventive care. This includes developing targeted registries and outreach programs aimed at increasing screening rates among underserved groups.

However, the financial challenges brought on by the COVID-19 pandemic, coupled with limited funding and incentives for such programs, have impacted our capacity to maintain dedicated focus on these efforts. But we remain committed to embedding these objectives into our broader organizational strategies and continuing to prioritize inclusive, patient-centered care.

— **Paul Pritchard, MD, MBA**, *Vice President and Chief of Quality, Prevea Clinic*

2. NAACOS. 2024. ACO drivers for success: Lessons from high-performing accountable care organizations. National Association of ACOs. www.naacos.com/wp-content/uploads/2024/09/ACODriversForSuccessWhitePaper.pdf

partner with community-based organizations, patient navigators, and trusted local leaders. These partnerships enable providers to extend their reach beyond the clinical setting and connect patients with the resources they need to thrive.

Embedding community health workers and patient navigators into care teams is especially critical. These individuals bridge the gap between providers and patients, helping navigate care, build trust, and ensure cultural and linguistic alignment. For example, patient navigators can ensure adherence to care plans by coordinating with community-based organizations that support transportation, nutrition, and adequate housing concerns for patients. Their presence not only reduces logistical barriers, but also helps tailor care to the unique needs of each community.

Federal models like the Accountable Health Communities Model have shown promise in aligning clinical care with social services, but widespread impact depends on adequate funding, policy flexibility, and long-term sustainability. Expanding and scaling these types of initiatives is essential to achieving the goal of transforming healthcare into a truly accountable ecosystem.

Conclusion

Ultimately, achieving optimal health outcomes requires both a well-supported healthcare system and the active involvement of non-health sectors. Policymakers must strike this balance, enabling the healthcare system to focus on what it does best—providing care—while fostering cross-sectoral collaboration to address the root causes of health disparities and chronic disease. Without this balance, efforts to advance optimal health outcomes for all populations may falter, leaving our nation to continue bearing the burden of preventable health disparities.

Wendy Ferrell-Smith on the Importance of Addressing Social Drivers of Health

Our high-value care team utilized reporting from our payers to identify patients with confirmed and predicted social drivers of health (SDOH) who were in the doughnut hole and on branded medications. These patients are statistically more likely to suffer from non-adherence, leading to increased utilization. We proactively reached out to these patients using both social workers and certified pharmacy technicians to offer help with navigating patient assistance programs. We processed 219 applications, of which 142 were approved, resulting in $771,164 in savings in 2024 to the service pool for Medicare patients. These same patients, once renewed, will lead to $1,222,925 saved in 2025. Patients on assistance programs have no cost to their medications, which in turn removes the financial SDOH barrier and contributes to the health equity in our patient population.

— **Wendy Ferrell-Smith, MHI, BSN, CCM,**
Chief Value Based Care Officer, Summit Medical Group

Case Study:

Addressing Health Outcomes Challenges at Northwell Health

Northwell Health, the largest employer in the state of New York, is committed to improving health outcomes and reducing disparities within its diverse patient population. While its mission prioritizes advancing health equity, the organization faces challenges related to standardized metrics, technological integration, and infrastructure for addressing social drivers of health. These barriers reflect broader systemic issues, underscoring the complexities of achieving health equity in high-value care models.

Background

Northwell Health serves patients from a highly diverse geography from varied socioeconomic and cultural backgrounds. The health system has recognized the critical role of addressing social drivers of health, which can account for up to 80% of health outcomes. However, without comprehensive standardized metrics, robust data systems, and seamless technology integration, efforts to implement equity-driven interventions face limitations.

Challenges

1. **Lack of Standardized Metrics for Equity**

   Northwell Health has struggled with the absence of consistent health equity metrics, a common issue among healthcare systems transitioning to high-value care. Without standardized health equity metrics, it becomes difficult to measure disparities, assess progress, and compare outcomes across populations. For example, each high-value care contract or arrangement has slightly different attribution models or focuses within the health equity space. It makes it difficult to apply universal approaches to addressing gaps in care through a population health lens. Instead, health systems have to focus on the overlap, as addressing all metrics in every contract becomes too burdensome from a resource perspective.

2. **Fragmented Technology Infrastructure**

   As Northwell Health moved toward digital transformation, gaps in technology integration emerged as a significant barrier. Legacy systems, coupled with disparate electronic health record (EHR) platforms, hindered the seamless flow of patient data across care settings. The fragmentation makes it difficult to view data across an entire system. For example, information is typically shared through spreadsheets or added to a data warehouse, which requires significant resources and technical expertise. This process leads to fragmentation, limiting the organization's ability to effectively coordinate care and address nonmedical needs, such as housing, transportation, and food security.

3. **Challenges in Data Collection and Utilization**

   Robust data collection is essential for identifying health disparities and developing targeted interventions. However, Northwell Health encountered difficulties in capturing comprehensive social drivers data within its EHR systems. Each EHR system typically has its own workflows and screening tools. To ensure consistency, significant effort is needed to standardize the work. Ramsey Abdallah, assistant vice president of quality at Northwell Health, added, "We are undergoing a significant review of our systems to standardize where possible. This will enable us to obtain the granular data needed to analyze trends and better address the unique needs of vulnerable populations." He went on to add, "The bigger challenge will come with the training and implementation of the new workflows. Given our geographic region and its diversity, we have to tailor our approach to the local community."

4. **Limited Interoperability**

   Northwell Health's efforts to collaborate with external partners, such as community organizations and public health agencies, were constrained by interoperability issues. For example, when a social driver such as food insecurity is identified, a referral can be made to a community-based organization. They can easily track the number of referrals, but the current system makes it difficult to detect if the referral loop was closed and if the issue was addressed. In the current state, most of this information is exchanged through spreadsheets, emails, or other non-digital, non-automated methods. These challenges prevented the effective exchange of critical patient data, further complicating efforts to address health inequities holistically.

Strategies and interventions

Despite these challenges, Northwell Health has made concerted efforts to overcome systemic barriers and embed health equity into its care delivery models. Key strategies include:

1. **Investing in Health IT Systems**

   Recognizing the limitations of its existing technology infrastructure, Northwell Health prioritized investments in interoperable health IT systems. The health system has elected to migrate to Epic as the enterprise solution. By adopting a single EHR, they are able to capitalize on Epic's enhanced capabilities and more easily build integrations of social driver data. This is driven by the fact that there would be fewer external integrations needed and that Epic has established integrations already available. Northwell Health hopes this will accelerate their ability to gain actionable insights into patient needs and disparities.

2. **Collaborating with Community Partners**

   To address gaps in care, Northwell Health expanded partnerships with community organizations focused on housing, nutrition, and transportation. For example, they have partnered with Island Harvest, Long Island Cares Inc., The Harry Chapin Food Bank, God's Love We Deliver, US Foods, and Baldor to start Food as Health, which helps communities deemed as "food deserts" by delivering healthy foods to homes where residents are hampered by chronic illness due to poor nutrition. Northwell Health is also collaborating with Chicago-based startup NowPow to utilize a platform that connects patients to community-based organizations, as well as with Harlem Grown, a network of urban farms providing underserved children with the skills and knowledge to produce sustainable and healthy food for their families and community. More recently, Northwell Health has continued its efforts to expand access to nutritious food by partnering with InstaCart Health. The leading grocery technology company in North America provides tools and resources to Northwell Health staff, patients, and communities that address social drivers of health, including access to healthy food and transportation. These collaborations enabled the health system to connect patients with essential resources and mitigate nonmedical barriers to health.

3. **Embedding Equity Metrics in High-Value Care Models**

   Northwell Health has advocated for the inclusion of health equity metrics in high-value care reimbursement structures. By tying financial incentives to equitable outcomes, the organization seeks to ensure that underserved populations receive the targeted care they need. Additionally, Northwell Health has embedded health equity into its internal dashboards and applies a health equity lens to system priorities. A key example is the Accountable Care Organization (ACO) metrics, through which they track and trend performance by race, ethnicity, and preferred language. By trending data through an equity lens, the organization is better able to identify potential gaps, even in metrics that appear to be performing well in aggregate.

4. **Training and Capacity Building**

   To support these initiatives, Northwell Health implemented staff training programs focused on culturally competent care and the collection of equity-related data. The organization is committed to building a workforce ready to address the challenges of tomorrow. These efforts align with the organization's broader goal of fostering an inclusive and responsive care environment.

Outcomes and lessons learned

While challenges persist, Northwell Health's efforts to integrate equity into its operations have yielded promising outcomes. Improved data collection processes have enabled the organization to identify disparities more effectively and develop targeted interventions. For example, through the integration of health equity data, Northwell Health has been able to identify practices in select ZIP codes where hypertension control rates are lower, enabling the team to design targeted interventions to that community. Additionally, partnerships with community organizations have strengthened Northwell Health's ability to address social drivers of health at scale.

Key lessons from Northwell's experience include the importance of:

- Standardizing equity metrics to ensure consistent measurement and accountability
- Investing in interoperable technology systems that facilitate seamless data sharing
- Engaging community partners to address social drivers of health comprehensively
- Advocating for policy reforms that align financial incentives with equitable outcomes

Conclusion

Northwell Health's journey highlights the complexities of advancing health equity in a fragmented healthcare landscape. While systemic barriers related to measurement, technology, and integration remain significant, the organization's commitment to high-value care provides a strong foundation for driving equitable outcomes. By addressing these challenges through targeted investments, collaborations, and advocacy, Northwell Health continues to serve as a model for other healthcare systems navigating similar obstacles.

Protect Patient Dignity at End of Life

AMGA Goal

Safeguard the dignity and wishes of patients by facilitating open conversations about desired end-of-life medical care and goals and by ensuring benefit designs and models of care enable patients to receive this care in a manner respecting their wishes.

AMGA values the importance of respecting patient wishes as they approach death. To respect the dignity and needs of patients nearing the end of life, AMGA recommends Congress take a holistic approach to improving end-of-life care for Americans by enhancing and improving Medicare coverage for end-of-life care, supporting education and outreach efforts for patients and their families, and engaging with the non-healthcare community to support patients in their communities at the end of life.

End-of-life care encompasses both palliative care, which alleviates suffering for patients undergoing treatment, and hospice care, which focuses on providing comfort for those facing terminal illnesses. Distinguishing between palliative care and hospice care is essential. Palliative care focuses on alleviating suffering and improving the quality of life for patients undergoing treatment for serious illnesses, regardless of their prognosis. Palliative care often is provided alongside curative treatments and addresses symptoms like pain, nausea, and fatigue across various stages of illness. In contrast, hospice care is specifically designed for terminally ill patients who are nearing the end of life and forgo curative treatments in favor of quality of life. The primary aim of hospice care is to provide comfort and to support patients and their families through an approach that addresses physical, emotional, and spiritual care. Both forms of care prioritize comfort but serve patients at different stages, with hospice care reserved for those nearing life's end.

Why End-Of-Life Care?

About 15 to 20 years ago, I admitted an elderly gentleman four times to the hospital in a six-month period. After he subsequently died of heart failure, his family approached me and thanked me for taking care of their loved one. Their only regret was the "suddenness" of his passing.

I felt very small at the point. Their loved one had been slowly dying from the day we met, as he had heart failure, and the only thing I could do was tweak medications when he had a brat during the Packer's game. But I failed to prepare them, as I had tunnel vision and was treating symptoms and not the patient.

— **Paul Pritchard, MD, MBA**, *Vice President and Chief of Quality, Prevea Clinic*

Understanding and distinguishing these forms of care is vital for improving patient experiences and outcomes. End-of-life care involves providing medical, emotional, and supportive services to individuals nearing life's end, aiming to enhance their quality of life and uphold their dignity.

The current landscape of end-of-life care is influenced by Medicare Hospice Benefit's per diem reimbursement and six-month prognosis criteria, which is based on hospice's traditional focus on cancer patients. This focus, however, is shifting due to changing patient demographics, as hospice patients are increasingly diagnosed with non-cancer conditions.

AMGA recommends Congress:

- **Establish a Total-Cost-of-Care Model for End-of-Life Care**: Develop a comprehensive framework that encompasses all aspects of care delivery and reimbursement to address the holistic needs of patients.
- **Engage Community and Non-Healthcare Stakeholders**: Support partnerships with community organizations to foster collaborative discussions that broaden support for end-of-life care. Engaging various stakeholders promotes a more inclusive dialogue around patient preferences and needs.
- **Implement Outreach and Education Programs**: Launch initiatives involving healthcare providers, community leaders, and advocates to create a supportive environment for end-of-life care discussions. These programs empower patients and families to make informed decisions about care options.
- **Expand Medicare Coverage for End-of-Life Care**: Adjust fee-for-service models to better account for advanced illness planning and care coordination services. Additionally, build on existing models to include individuals who do not require nursing home-level care, offering broader comprehensive support for those facing serious health challenges.

Establish a total-cost-of-care model for end-of-life care

The integration of end-of-life care into high-value care models has emerged as a vital component in the effort to transform healthcare systems, ensuring that patients receive compassionate and respectful care during their final days. AMGA supports this initiative by advocating for policies that prioritize patient-centered approaches to end-of-life care. This integration honors the dignity and wishes of individuals, while addressing the distinct needs of an aging population.

Incorporating end-of-life care within high-value care models not only meets patients' emotional and physical needs but also supports health system efficiency. By encouraging open discussions among providers, patients, and families, patients are empowered to make informed choices that align with their preferences. Benefits of prioritizing end-of-life care within high-value care frameworks include increased patient satisfaction, better resource management, and lower costs associated with hospitalizations and aggressive interventions. Further, palliative care improves quality of life for patients and their families, while also avoiding unnecessary care.[1] Congress has previously considered the importance of such advanced care planning, and AMGA strongly encourages Congress to build on its previous work.[2]

Integrating end-of-life care within high-value care frameworks presents challenges. Many providers lack necessary training to engage in meaningful conversations about patients' goals and preferences. Additionally, existing

1. World Health Organization Fact Sheet on Palliative Care, August 5, 2020
2. "Collins, Warner Introduce Bipartisan, Bicameral Legislation to Expand Access to Advance Care Planning," Nov. 24, 2022. www.collins.senate.gov/newsroom/collins-warner-introduce-bipartisan-bicameral-legislation-to-expand-access-to-advance-care-planning

reimbursement models often fail to address the complexities of end-of-life care, which can lead to misaligned priorities in care delivery. To address these challenges, AMGA urges Congress and stakeholders to develop and adopt comprehensive policies that embed end-of-life care principles into high-value care models, ensuring that all patients receive the care they desire and deserve.

The shift in patient demographics presents an opportunity to reassess and modernize current models to better address complex, varied needs through expanded palliative care access, earlier intervention, and high-value care models. Partnerships between hospice providers and Accountable Care Organizations (ACOs) could further enhance care coordination, align financial incentives with patient-centered goals, and improve outcomes.

To advance this effort, AMGA recommends the Centers for Medicare & Medicaid Services (CMS) develop a total-cost-of-care model that goes beyond traditional payment structures and directly reimburses providers for engaging in meaningful conversations with patients and their families. These discussions would help facilitate informed decisions about palliative care options and hospice enrollment, ensuring that care aligns with patients' values and preferences. A total-cost-of-care model should represent a holistic framework that integrates all aspects of care delivery, quality measures, and reimbursement strategies to address the complex needs of end-of-life patients as comprehensively as possible. Such a model could build on the Medicare Care Choices Model, which found "some terminally ill Medicare beneficiaries will accept supportive and palliative care services if they do not have to forgo payment for the treatment of their terminal conditions."[3]

Engage community and non-healthcare stakeholders

Congress and CMS should engage community organizations, faith-based groups, and other non-healthcare stakeholders to foster a more comprehensive and culturally sensitive approach. Community organizations are often trusted entities and can serve as effective liaisons for educating individuals about palliative care options and advanced care planning. Congress and CMS can expand awareness campaigns that resonate with diverse populations by providing grants and partnerships to these organizations. Faith-based groups, for example, can play a crucial role in addressing cultural and spiritual concerns related to end-of-life decision-making, helping families navigate these complex conversations with a foundation of trust.

Non-healthcare stakeholders, such as legal aid services, can also contribute to end-of-life care improvements by addressing ancillary needs that affect quality of life. For example, legal organizations can assist individuals in creating advance directives or wills, ensuring their healthcare preferences are honored. Businesses can offer employee education programs on caregiving and bereavement support, fostering a culture of understanding around end-of-life issues. By creating collaborative networks that incorporate these diverse stakeholders, Congress and CMS can broaden the scope of end-of-life care beyond traditional healthcare settings, ensuring that patients and their families receive holistic and community-centered support.

Implement outreach and education programs

Congress and CMS can significantly improve the quality and accessibility of end-of-life care by implementing comprehensive outreach and education programs that empower patients, families, and healthcare providers to make informed decisions. These programs should aim to raise awareness about the importance of advance care planning, including tools such as living wills, healthcare proxies, and documented care preferences. Such initiatives could include public education campaigns to normalize conversations about end-of-life care, addressing cultural stigmas and fostering an understanding of hospice and palliative care services.

3. Medicare Care Choices Model, Fifth and Final Annual Evaluation Report

For healthcare providers, CMS should fund and support training programs designed to enhance communication skills, ensuring clinicians feel confident and equipped to engage in sensitive discussions about prognosis, treatment options, and patient values. Education efforts should support shared decision making and explain the efficacy of treatment options and how futile efforts negatively affect quality of life. Outreach efforts should leverage technology, such as telehealth platforms, and community partnerships to deliver resources to diverse populations, particularly in underserved or rural areas. Multilingual materials and culturally tailored content would be critical to ensuring equitable access to these educational opportunities. While there is some federal support for caregivers, it is largely restricted to Medicaid or veterans programs.

Federal support for caregivers also is an economic necessity. The financial and emotional toll on caregivers is substantial, often leading to reduced workforce participation and increased reliance on public assistance. Investing in caregiver support programs can yield significant economic benefits by enabling caregivers to remain in the workforce and reducing their financial strain. Supporting caregivers also helps maintain their health and well-being, potentially reducing healthcare costs associated with hospitalizations and institutional care. As the population ages, the demand for caregiving will only grow, making federal investment in caregiver support both a compassionate choice and a strategic economic decision.

Additionally, Congress should allocate funding to pilot programs that integrate end-of-life care discussions into routine care, such as Annual Wellness Visits, during which clinicians can assess and document care preferences early. By fostering an informed, patient-centered approach, these initiatives can reduce unnecessary interventions, align care with individual values, and ultimately improve patient and family satisfaction, while also alleviating the emotional and financial burdens often associated with end-of-life care.

Benefits of Palliative Care

A Wisconsin nonprofit hospice and palliative provider and partner of an AMGA member conducted an analysis of an aggregate of 160 patients who were in their palliative program in 2022.

These 160 patients had 181 ER visits during the 6 months prior to admitting into their program. These same patients had only 57 ER visits for the 6 months after program admission.

- ER reduction of 69%.
- This is savings of $558,000 based on an average cost per ER visit of $4,500 (Data source: WHA price point)

These same 160 patients had 119 hospitalizations during the 6 months prior to program admission and only 38 hospitalizations for the 6 months after admission.

- Hospitalization reduction of 69%

This represents savings of $2,976,021 to the Medicare program, based on an average cost per hospitalization of $36,741.

Expand Medicare coverage for end-of-life care

Expanding Medicare coverage for end-of-life care would ensure patients and families receive comprehensive, compassionate, and equitable support during a critical stage of life. Current Medicare benefits for hospice and palliative care provide valuable services, but often fall short in addressing the full spectrum of patients' needs, such as earlier access to palliative care and broader coverage for innovative care delivery models. To address these gaps, Congress should amend Medicare policies to include more flexible eligibility criteria for hospice, allowing patients to receive concurrent curative and palliative treatments. This approach, along with improved reimbursement to ensure palliative care and hospice care is appropriately reimbursed, would help align care with patient preferences and reduce the difficult choice between seeking life-prolonging treatments and receiving comfort-focused care. Currently,

Medicare reimbursement does not adequately cover the infrastructure, such as triage nurse and transportation services, needed to provide palliative and hospice care. Historically, AMGA members report these services only survive through subsidies from other service lines and community philanthropy.

Additionally, Medicare should expand reimbursement for caregiver support, mental health counseling, and bereavement services to ensure that families have the resources they need. Telehealth should also be fully integrated into end-of-life care coverage, enabling patients in rural or underserved areas to access palliative care specialists without traveling. Furthermore, expanding pilot programs like the Medicare Care Choices Model, which allows patients to receive palliative services alongside standard treatments, could provide valuable insights into sustainable ways to improve care quality while managing costs. Congress and CMS should build on the Program of All-Inclusive Care for the Elderly (PACE) model of care, which provides comprehensive medical, emotional, and supportive services to help seniors remain in their communities. PACE is based on the idea that most older adults prefer to receive care at home rather than in a nursing home. Currently, Medicare reimburses PACE at a capitated rate for beneficiaries identified by the state as needing nursing home-level care. AMGA recommends CMS expand coverage of the PACE model to allow more individuals access to essential end-of-life care, particularly for patients receiving palliative but nonterminal care. This approach reflects a nuanced understanding of end-of-life needs, allowing comfort-focused care regardless of terminal status. AMGA is also optimistic about the Guiding an Improved Dementia Experience (GUIDE) Model, a voluntary nationwide model test that aims to support people with dementia and their unpaid caregivers.

By broadening Medicare coverage, policymakers can help create a healthcare system that prioritizes dignity, comfort, and patient-centered decision making at the end of life.

Conclusion

Addressing end-of-life care is fraught with difficulties, but AMGA contends it is a vital aspect of any serious effort to improve Medicare from both a beneficiary coverage and a provider reimbursement standpoint. Many patients nearing the end of life undergo invasive and expensive interventions—such as feeding tubes and dialysis—that often offer little benefit in terms of extending life or enhancing its quality. Although most individuals express a preference to spend their final days at home, many still die in hospitals or nursing facilities after experiencing multiple transitions between care settings. Bereaved family members frequently report shortcomings in end-of-life care, including inadequate pain control for 25% of patients, high rates of emotional distress (56% experienced anxiety or depression), and unmet spiritual needs for more than 40% of decedents.[4] Medicare spends roughly 25% of its total budget on patients in their final year of life, with median spending during the last six months exceeding $25,000 in many regions.[5] Engaging patients, families, and friends in this journey empowers individuals, providing comfort during life's final stage. The future of end-of-life care should prioritize patient-centered principles, ensuring compassionate, dignified care. By developing a total-cost-of-care model, engaging diverse stakeholders, expanding education and outreach, and enhancing Medicare coverage, policymakers, providers, and stakeholders can collectively ensure individuals receive the highest quality end-of-life care.

4. Nicholas LH, Fischer SM, Arbaje AI, Perraillon MC, Jones CD, Polsky D. Medicare-Covered Services Near the End of Life in Medicare Advantage vs Traditional Medicare. JAMA Health Forum. 2024;5(7):e241777. doi:10.1001/jamahealthforum.2024.1777

5. Ibid

Remove Regulatory and Legislative Barriers to High-Value Care

AMGA Goal

Ensure patients receive coordinated, patient-centric care in the most appropriate settings by removing regulatory and statutory obstacles to care delivery and provider operations.

In recent years, Congress and the Centers for Medicare & Medicaid Services (CMS) have worked to remove the barriers and obstacles that prevent medical group practices and integrated systems of care from delivering the highest quality care in the most efficient and cost-effective way. AMGA recommends building on these efforts by continuing to modernize Medicare laws and regulations to support care delivery patterns which have evolved since Medicare's inception.

Despite reforms, such as Medicare Access and CHIP Reauthorization Act of 2015, and a variety of demonstrations, Medicare laws and regulations remain rooted in the healthcare delivery model prevailing in 1965 when the program was enacted. At that time, Medicare's structure and rules reflected current care standards, which emphasized acute care delivered in hospitals or individual physician practices. These regulations, while appropriate for the era, do not fully account for the modern realities of healthcare, such as the rise of team-based care, the shift toward outpatient and home-based services, advancements in technology, and the emphasis on high-value care. As a result, patients must navigate a complex system that has developed over time based on outdated rules that constrain innovation and create inefficiencies. This has created unnecessary challenges for healthcare providers to deliver coordinated, high-quality care. Modernizing Medicare statute and regulations to reflect the evolution of care delivery—embracing new care settings, interoperability, and payment models—will be critical to meeting the needs of an aging population and supporting a more effective healthcare system. Doing so is critical to ensure Medicare beneficiaries benefit from the right care at the right time in the right setting.

AMGA recommends reforming Medicare statutes and regulations to promote broader adoption of high-value care, both in value-based care models and traditional Medicare by removing regulations that hinder the operations of group practices and integrated systems without improving access to care or the quality of care.

AMGA recommends Congress:

- **Reform quality measures based on AMGA's Value Measure Set**: Quality measures must prioritize outcomes-focused metrics and reduce unnecessary reporting burdens.
- **Modernize the physician self-referral laws to account for changes in high-value care**: High-value models of care should be exempt from self-referral laws, and providers should have the flexibility to identify the most appropriate post-acute care facilities for their patients.
- **Reform documentation and billing rules**: Current documentation and billing requirements are excessive and often repetitive, creating administrative burden and delays.

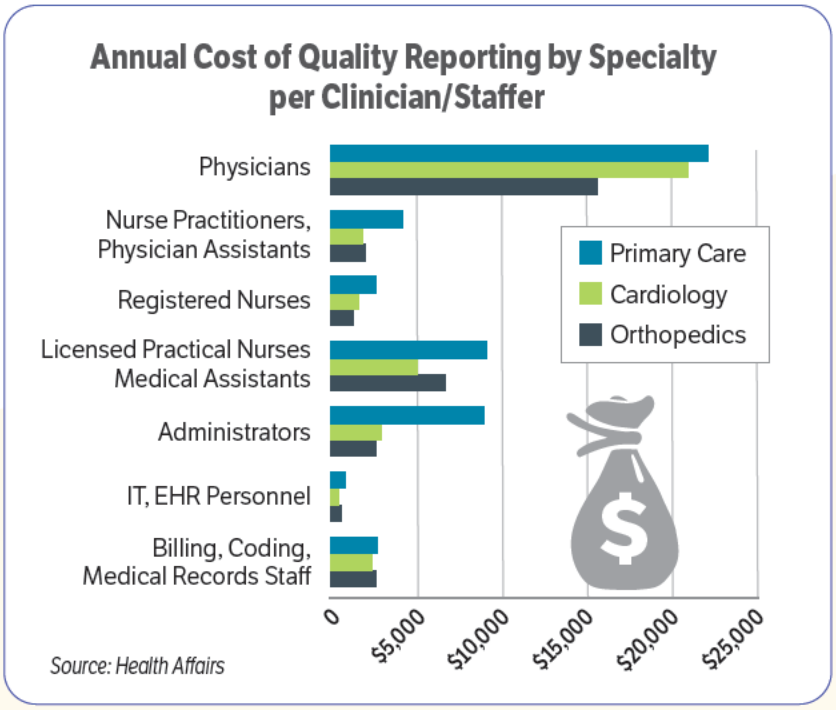
- **Reform Medicare Advantage prior authorization to eliminate delays in care**: Prior authorization results in significant delays and administrative burdens and should be eliminated to the extent possible.
- **Reform post-acute care payment silos**: The lack of a unified payment framework for post-acute care inhibits seamless transitions between care settings and creates barriers for providers who are striving to deliver integrated, high-value care.
- **Eliminate the three-day stay requirement for skilled nursing facility (SNF) care**: The requirement for a three-day inpatient hospital stay as a prerequisite for coverage of skilled nursing facility (SNF) care is outdated and unnecessarily restrictive. Eliminating it would reduce hospital congestion, improve care coordination, and lower healthcare costs.
- **Reform Medicare Annual Wellness Visit rules**: Annual Wellness Visits require extensive documentation and data collection and entry, much of which is redundant since it has already been recorded in the patient's record.
- **Eliminate geographic and originating site restrictions for Medicare telehealth coverage**: The geographic and originating site requirements for Medicare telehealth coverage are outdated barriers that hinder access to care.
- **Permanently extend the ability to prescribe controlled medication via telehealth**: Congress should permanently waive the prohibition against the prescribing of controlled substances during a virtual visit.
- **Establish a national licensing framework**: A national licensing framework or an expanded interstate compact would allow physicians and other healthcare providers to practice in multiple states without duplicative licensing processes.

Reform quality measures based on AMGA's Value Measure Set

Quality measurement in the Medicare program plays a critical role in promoting high-value care, improving patient outcomes, and holding providers accountable. Medicare evaluates provider performance across domains, such as patient experience, safety, care coordination, and clinical outcomes. These metrics not only inform payment adjustments and plan ratings, but also help beneficiaries make more informed choices. However, the system faces ongoing challenges, including administrative burden, data lag, and questions about whether current measures truly reflect meaningful improvements in patient care. Improving quality measurement in Medicare requires adopting a streamlined and outcomes-focused approach, such as AMGA's Value Measure Set. This measure set emphasizes outcomes that matter most to patients while minimizing the administrative burden associated with overly complex and redundant reporting requirements. AMGA selected the 14 measures to address the flaws with the current quality measurement and reporting system, which suffers from duplicative measures and a lack of data standardization. AMGA members report hundreds of different quality measures to various public and private payers, the vast majority of which are not useful in evaluating or improving the quality of care provided. There is a significant cost to measure reporting. Research has indicated that, on average, U.S. physician practices across four common specialties annually spend more than $15.4 billion and 785 hours per physician to report quality measures.[1] By prioritizing measures that are evidence-based, actionable, and reflective of population health goals, Congress and CMS will promote high-value care. These changes would help providers focus on delivering high-quality, coordinated care rather than navigating fragmented and duplicative quality reporting systems.

1. Casalino LP, Gans D, Weber R, Cea M, Tuchovsky A, Bishop TF, Miranda Y, Frankel BA, Ziehler KB, Wong MM, Evenson TB. US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures. Health Aff (Millwood). 2016 Mar;35(3):401-6. doi: 10.1377/hlthaff.2015.1258. PMID: 26953292.

AMGA is pleased CMS introduced the Universal Foundation measure set as a streamlined framework to align quality reporting across its various programs. This measure set draws inspiration from AMGA's Value Measure Set, which prioritizes outcomes-focused metrics and the reduction of unnecessary reporting burdens. Incorporating AMGA's Value Measure Set into Medicare's quality programs—and eventually Medicaid programs—would help reduce reporting fatigue, promote provider engagement, and drive meaningful improvements in care delivery.



Modernize the physician self-referral laws to account for changes in high-value care

Physician self-referral laws, such as the Stark Law, were designed to prevent conflicts of interest in fee-for-service environments, but they have become misaligned with the evolving landscape of healthcare delivery. As care shifts toward high-value models emphasizing coordination, efficiency, and outcomes, these regulations often hinder innovative arrangements that incentivize collaboration among providers. Current laws create significant compliance challenges and limit opportunities to share savings or risk in ways that align with high-value care goals. Reform is needed for Accountable Care Organizations (ACOs), bundled payment programs, and other value-focused initiatives to thrive while maintaining safeguards against abuse. By adapting to be consistent with modern care delivery, reforms can promote improved care coordination and better patient outcomes. High-value care models should automatically be exempt from self-referral laws, as the incentives the prohibitions were intended to prevent do not exist in high-value care models.

In addition, providers in high-value care models need the flexibility and ability to identify the most appropriate post-acute care provider and facilities and provide this information to their patients. The use of preferred provider lists for post-acute care referrals can help improve patient outcomes by directing patients to high-quality facilities with proven records of accomplishment. Preferred provider networks are typically selected based on performance metrics—such as readmission rates, patient satisfaction, and adherence to care protocols—ensuring continuity of care and better health outcomes. For providers, these lists also streamline the referral process, reduce administrative burdens, and support alignment with high-value care goals by prioritizing care coordination. Additionally, guiding patients toward high-performing post-acute care providers can help optimize healthcare spending and avoid all of the problems associated with poor-quality care.

Reform documentation and billing rules

Modernizing Medicare's documentation and billing rules is critical to reducing administrative burdens and improving the quality of patient care. Many current rules are rooted in outdated practices and require excessive documentation for compliance purposes rather than for clinical necessity. These rules often lead to redundant tasks, such as

providers needing to document the same information in multiple formats, which takes time away from direct patient care. Adopting a streamlined approach, including the use of templates, electronic health records, and artificial intelligence tools, can improve efficiency and reduce errors.

The transition to high-value care requires substantial investments of time and money by healthcare providers. Practices must engage their legal teams to ensure compliance, retrain staff to accommodate new workflows, model financial performance under high-value models, and update IT systems to meet new reporting requirements. These efforts consume valuable time and resources that could otherwise be devoted to patient care. While successful implementation of high-value care can result in better patient outcomes and justify these investments, the administrative burdens should be minimized. Changes to existing models that introduce further burdens should only occur if absolutely necessary. Streamlining regulatory requirements and providing compliance support for providers will encourage participation in voluntary models while helping those in mandatory models focus more time on patient care and less time navigating complex rules.

A prime example of streamlining is the data collection process used to calculate the Composite Quality Score (CQS) in the upcoming Transforming Episode Accountability Model (TEAM). The CQS relies on quality measures already collected through the CMS Hospital Inpatient Quality Reporting (IQR) Program and the Hospital-Acquired Condition (HAC) Reduction Program.[2] By leveraging existing reporting systems rather than creating new requirements, CMS can significantly reduce the compliance burden on providers, encouraging participation and maximizing the time spent on patient care.

Signature Required

Determining which provider is required to sign a face-to-face order is complex and convoluted when an ambulatory provider (as opposed to a provider discharging a patient from an acute care setting such as a hospital or skilled nursing facility) orders home care.

When the face-to-face encounter is completed at a primary or specialty care appointment by a clinician who is not usually part of the patient's care team—such as a covering physician—Medicare regulations require that the provider must also sign the patient's home health plan of care and ongoing orders, as well as continue to follow the patient while they receive home health services. This requirement does not reflect how team-based care is provided.

Conversely, CMS should avoid introducing new requirements into high-value models without fully understanding their impact on clinical workflows. For example, the Increasing Organ Transplant Access (IOTA) Model would mandate that providers notify all patients on transplant waitlist of every instance when an organ was declined on the patient's behalf, along with the reasons for declination.[3] Although well intentioned, such a policy would impose significant administrative burden on smaller transplant programs and cause emotional distress to patients.

In 2017, CMS launched its Electronic Clinical Quality Measure (eCQM) Strategy Project aimed at balancing value and burden based on stakeholder feedback. Each individual CMS quality program determines the number of eCQMs a health system reports. Providers face a number of burdens in the implementation and reporting of eCQMs. Although CMS has worked hard to address some of these issues,[4] consistent burdens remain, such as documentation required for eCQM reporting not directly supporting patient care, multiple submission mechanisms and formats leading to delays and user challenges, and concerns with meaningful connections between certain eCQMs and quality

2. 89 FR 69775
3. 89 FR 43521
4. https://pmc.ncbi.nlm.nih.gov/articles/PMC8510288/#sec10

improvement. CMS should continuously evaluate its efforts to remove provider burden to encourage better high-value care participation. In fact, AMGA supports H.R. 483, Health Care Efficiency Through Flexibility Act, which delays the transition of ACOs from reporting quality measures via the CMS Web Interface portal to eCQMs.[5]

Additionally, frequent coding changes present significant challenges for providers. Given the immense financial impact of risk adjustment on high-value care models, changes to coding standards can necessitate reevaluating financial projections and making program adjustments if those projections worsen. Furthermore, clinicians need retraining to align with new standards and ensure appropriate documentation of patient health. Simplifying coding standards and offering comprehensive retraining programs would facilitate a smoother transition to high-value care.

Reform Medicare Advantage prior authorization to eliminate delays in care

CMS recently implemented new timeframes for Medicare Advantage (MA) prior authorizations to enhance transparency and reduce delays in care. As of 2024, plans must make a determination for standard prior authorization requests within seven calendar days, and expedited requests must be addressed within 72 hours. Additionally, plans must provide specific reasons for any denials, improving clarity for both providers and patients.

MA prior authorization rules and timelines often result in significant care delays for patients and administrative burdens for providers. These delays occur as providers wait for approvals for medically necessary services, which can create stress for patients needing timely care. Most prior authorization requests are ultimately approved on appeal, but the process consumes valuable time and resources, detracting from

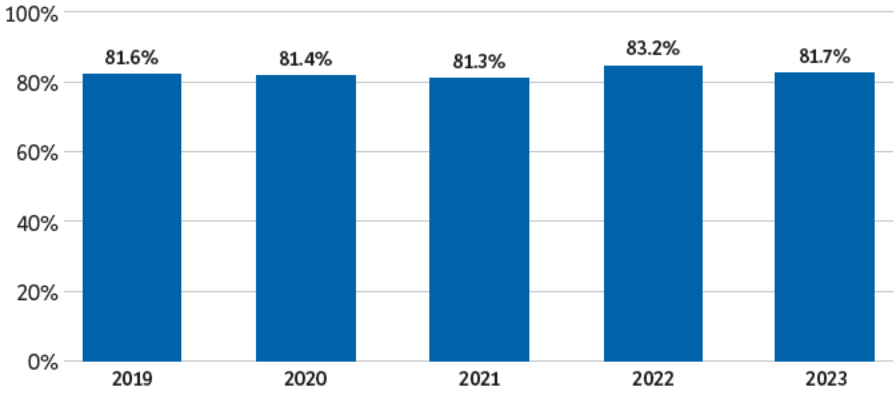
Dr. Scott Hines on Changes to Risk Adjustment

There is significant education that goes into ensuring that risk adjustment coding completely and accurately captures the disease burden of patients. There is also significant investment in systems that reduce the burden of coding accurately and completely. Changing the rules midstream means time and money needs to be spent revamping education and these systems. Beyond lost time and increased investment, revenue that is projected to come from risk coding is being reduced by millions of dollars each year, meaning that there are fewer resources available to reinvest in the ACO to better care for patients.

— **Scott Hines, MD**, *Chief Quality Officer, Crystal Run Healthcare*

More than 80% of Denied Prior Authorization Requests That Appealed Were Overturned

Share of reconsiderations that were fully or partially favorable, 2019–2023



Source: Medicare Limited Data Set, Contract Years 2022 and 2023 Part C and D Reporting Requirements, Public Use File, Part C and D Reporting Requirements Contract Years 2019–2021.

5. https://www.congress.gov/119/bills/hr483/BILLS-119hr483ih.pdf

patient care. The appeals process also highlights inefficiencies, as the high approval rates suggest that many initial denials may be unwarranted. These delays can exacerbate medical conditions, hinder access to critical treatments, and lead to frustration among patients and clinicians alike, underscoring the need for streamlined prior authorization policies. For example, an AMGA member reports instituting a 14-day delay in scheduling magnetic resonance imaging (MRI) simply to manage the denials from payers. While ultimately scheduled, approved, and reimbursed, the system effectively penalizes the patient.

> *"Hospitalized patients routinely wait days for prior authorization to allow them to continue their care at a skilled nursing facility. And if the request isn't back by Friday, the patient ends up staying all weekend at the hospital."*
>
> — **Dan Duncanson, MD**, *CEO, SIMEDHealth, LLC*

The need for prior authorization is also eliminated as more providers transition to high-value model of care, whether through MA plans or other models. High-value care shifts the focus from the quantity of services provided to the quality and outcomes of patient care, effectively eliminating incentives for unnecessary tests and procedures. Under traditional fee-for-service models, providers are reimbursed based on the number of services performed, which can lead to excessive testing and procedures, some of which may not be medically necessary. However, in a high-value care system, providers are rewarded for improving patient health outcomes, reducing hospital readmissions, and managing chronic conditions effectively. This approach naturally discourages the overutilization of services, thereby reducing the need for prior authorization—a process originally designed to control unnecessary costs. By aligning provider incentives with patient health rather than service volume, high-value care streamlines the approval process, minimizes administrative burdens, and ensures that patients receive only the most appropriate and necessary treatments.

Reform post-acute care payment silos

Medicare's payment silos for post-acute care services—such as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), home health agencies (HHAs), and long-term care hospitals (LTCHs)—create significant administrative burdens. Each type of care operates under distinct payment systems and quality reporting programs, with differing rules, documentation requirements, and reimbursement processes. This fragmentation requires providers to navigate complex regulations, leading to inefficiencies and delays in patient care coordination. The lack of a unified payment framework also inhibits seamless transitions between care settings, creating barriers for providers who are striving to deliver integrated, high-value care. Modernizing these payment systems to promote care coordination across settings would reduce administrative burdens, improve outcomes, and align with Medicare's broader shift toward high-value care delivery.

Eliminate the three-day stay requirement for skilled nursing facility (SNF) care

The rule requiring a three-day inpatient hospital stay as a prerequisite for coverage of SNF care is outdated and unnecessarily restrictive. This policy, established when hospital stays were longer and healthcare delivery was less advanced, no longer reflects the capabilities of modern medicine. Today, many patients can safely transition to SNF care or receive similar support without an extended hospital stay. Eliminating this requirement would reduce hospital congestion, improve care coordination, and lower healthcare costs by allowing clinicians to determine the appropriate level of care based on medical necessity rather than arbitrary length-of-stay criteria. Moreover, doing so aligns with Medicare's broader efforts to promote high-value care, enabling quicker access to post-acute services and better patient outcomes.

ACOs and MA plans benefited from CMS' ability to waive the three-day stay requirement, and they have demonstrated lower hospitalization rates and improved care coordination, emphasizing the benefits of a more flexible, patient-centered approach to SNF utilization. By eliminating the mandatory three-day stay, as was done during the COVID-19 public health emergency (PHE), the waiver supports a more efficient and cost-effective healthcare system while enhancing patient outcomes. The waiver of the Medicare-required three-day hospital stay for SNF coverage has significantly reduced costs and improved patient outcomes by allowing for more direct and efficient transitions to post-acute care.[6] Waiving this requirement enables patients to receive timely rehabilitative care, reduces hospital congestion and overall expenditures, and improves functional recovery as well as reduces readmission rates.

Reform Medicare Annual Wellness Visit rules

The Medicare Annual Wellness Visit (AWV), introduced as part of the Affordable Care Act, is intended to promote preventive care for beneficiaries. However, it has become a source of significant administrative burden for providers. The AWV requires extensive documentation, including the creation of a personalized prevention plan and the review of a detailed health risk assessment. These requirements often demand time-consuming data collection and entry, much of which is redundant, as it has already been recorded in the patient's record. The complexity of compliance detracts from time better allocated to direct patient care. Also, the lack of alignment with other Medicare quality initiatives compounds the inefficiencies. Simplifying the AWV process and integrating it into existing care delivery frameworks would reduce provider burden while maintaining its preventive benefits.

Improving Medicare's Annual Wellness Visits

AMGA recommends Medicare Annual Wellness Visits (AWVs) be expanded to address chronic medical conditions.

Current rules only allow providers to address preventative health during an AWV.

If patients ask about their diabetes, hypertension, chronic obstructive pulmonary disease, or other chronic conditions, either providers are not allowed to address it at that visit or they trigger a copayment for the visit.

To bill for an AWV that included addressing a chronic condition, providers must submit a modifier.

Providers who submit too many modifiers are audited, so providers are afraid to do this.

Under current rules, patients are inconvenienced by having to either make another visit or they are upset because they have a copayment for a "free" Medicare AWV.

Eliminate geographic and originating site restrictions for Medicare telehealth coverage

Telehealth serves as an excellent case study for demonstrating how a supportive policy framework can positively affect patient care through advances in technology. Before the COVID-19 PHE, telehealth utilization was extremely low.

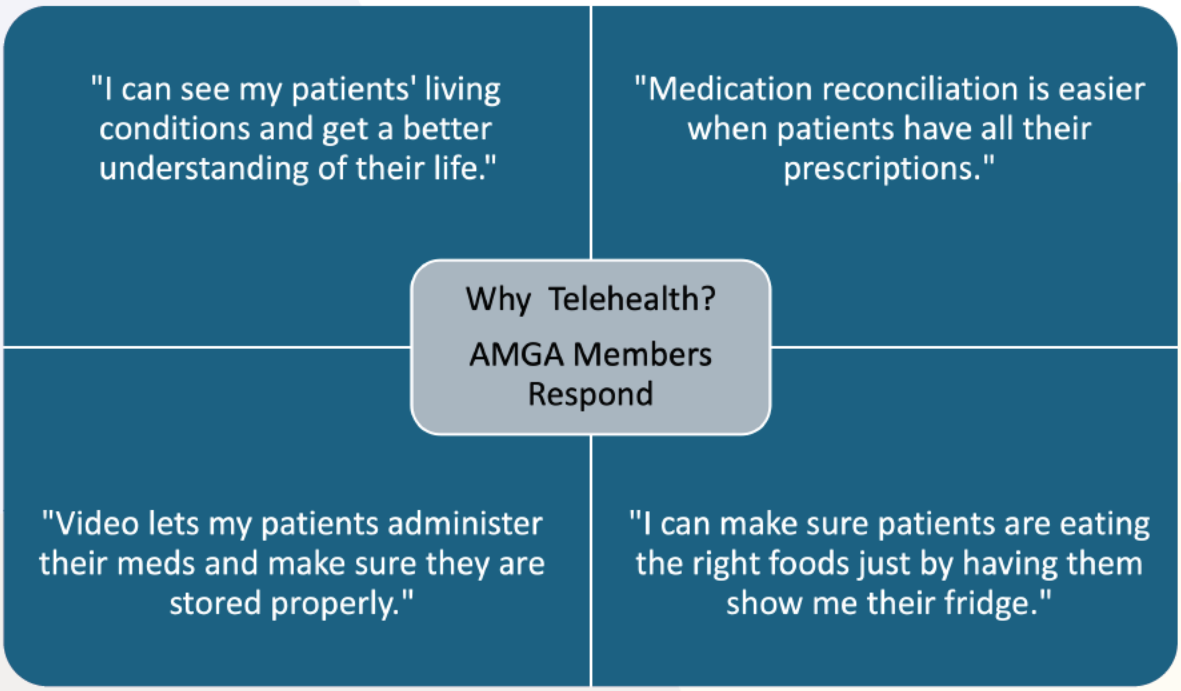
Under traditional Medicare rules, telehealth services generally are covered only if the patient is located at an approved originating site, such as rural health clinics, federally qualified health centers, hospitals, physician offices, or SNFs. Notably, the list of eligible originating sites in the Social Security Act does not include the patient's home,[7] requiring patients to travel to physician offices or clinics to receive care. Prior to the COVID-19 PHE waiver flexibilities, this statutory barrier presented a major care access issue for patients with limited transportation, who would have greatly benefited from provider care via telehealth communication technology. Further, outside of certain Medicare

6. Center for Medicare and Medicaid Innovation, Skilled Nursing Facility 3-Day Waiver: Analysis of Use in ACOs 2014 to 2019. Available at www.cms.gov/priorities/innovation/data-and-reports/2023/snf-waiver-summary

7. 42 CFR 410.78(b)(3)

demonstration projects, patients were required to receive telehealth services from an eligible "originating site" located in a rural health professional shortage area (HPSA) or a county not included in a Metropolitan Statistical Area.[8] These restrictions aim to target areas with limited access to in-person healthcare services, but exclude many urban or suburban beneficiaries who could also benefit from telehealth.

Further, allowing healthcare providers to conduct telehealth appointments outside of their usual facility offers numerous benefits for both patients and the healthcare system. Providers can offer more flexible scheduling, reducing wait times and improving continuity of care. This flexibility also helps alleviate provider burnout by allowing them to deliver care from a location—including their own homes—that best suits their workflow, ultimately increasing efficiency. Additionally, in times of PHEs or natural disasters, remote telehealth capabilities ensure that patients continue to receive necessary medical attention without overwhelming healthcare facilities.



The geographic and originating site requirements for Medicare telehealth coverage are outdated barriers that hinder access to care, particularly for beneficiaries in underserved and rural areas. These requirements, which limit telehealth services to specific locations such as rural areas and approved healthcare facilities, fail to account for the widespread adoption of telehealth technology and its demonstrated effectiveness in delivering care across settings. Eliminating these restrictions would allow beneficiaries to receive telehealth services while in their homes or other convenient locations, fostering greater equity in access to care. Removing these limitations aligns with the modern realities of healthcare delivery, supports care continuity, and enhances the ability of Medicare to meet the needs of an increasingly tech-savvy patient population. By modernizing telehealth regulations, Medicare can expand access to timely, high-quality care, particularly for those who face mobility, transportation, or geographic barriers.

The waiver of originating site and geographic location requirements during the PHE allowed medical group practices and integrated systems of care to have embedded telehealth in their clinical workflow. Telehealth enhances patient engagement, which is fundamental to the success of high-value care models. Therefore, it is critical for Congress

8. 2 CFR 410.78

to make these flexibilities permanent, such as through the Creating Opportunities Now for Necessary and Effective Care Technologies for Health Act.[9]

> *"The possibility of losing telehealth services already has created chaos in our endocrinology and behavioral health departments."*
>
> — **Paul Pritchard, MD, MBA**, *Vice President and Chief of Quality, Prevea Clinic*

Permanently extend the ability to prescribe controlled medication via telehealth

The ability to prescribe controlled medications via telehealth has proven essential in expanding access to care, particularly for patients in rural or underserved areas and those managing chronic conditions, pain, or mental health needs. During the COVID-19 PHE, temporary waivers allowed telehealth prescribing without requiring an in-person evaluation, enabling patients to receive timely and necessary treatments. As virtual healthcare expands, permanently extending this ability to prescribe controlled substances during a virtual visit is critical to ensuring continuity, reducing barriers to care, and addressing provider shortages. Safeguards against misuse can be maintained while leveraging telehealth to meet the growing demand for accessible, patient-centered care. Congress should permanently waive the prohibition against the prescribing of controlled substances during a virtual visit.

Establish a national licensing framework

As healthcare delivery increasingly incorporates telehealth and mobile technologies, the need for a national physician and provider licensing framework has become more pressing. Current state-by-state licensing requirements create significant barriers for patients requiring continuity of care or specialized expertise from their known and trusted physicians. A national licensing framework or an expanded interstate compact would streamline this process, enabling physicians and other healthcare providers to practice in multiple states without duplicative licensing processes. This reform would enhance access to care and ensure patients have the option of receiving treatment from a care team familiar with their history and individual needs.

A national framework is particularly useful for patients in rural settings or for patients who need to access specialists, which can be a challenge in large parts of the country. By nationalizing the medical license, these patients can access care across state lines via telehealth. This reform also recognizes that many integrated healthcare systems are multi-state. As a result, these systems may have specialists and subspecialists located in an urban setting or near a tertiary care hospital in one state that is unavailable to patients living in neighboring states via telehealth, necessitating a potentially long drive.

Conclusion

Effective collaboration among stakeholders is crucial for overcoming barriers due to outdated Medicare statutes and rules. Providers, payers, policymakers, and patient advocacy groups must work together to identify and address challenges.

Addressing statutory and regulatory barriers will help reduce administrative complexity in the healthcare system and ensure Medicare's promise from the 1960s matches the on-the-ground experience of patients and clinicians today. Modernizing Medicare laws and regulations will improve provider operations and reimbursement structures, which ultimately will improve healthcare delivery and the patient experience. A list of additional barriers are detailed in the table on the next page.

9. https://www.britt.senate.gov/wp-content/uploads/2025/04/connect1.pdf

Regulatory and Legislative Barriers

Barrier	Issue	Citations/Reference Points
Prior Authorization	The prior authorization process leads to delay in patient care and payment reductions due to cumbersome requirements and errors, resulting in payers forgoing payment for appropriate medical services.	42 CFR Chapter IV, Subchapter B: §422.122, §422.568, §422.570, §422.572
Merit-Based Incentive Payment System (MIPS) Low Volume Threshold	Exempting too many providers from the Merit-Based Incentive Payment System (MIPS) undermines the program and minimizes rewards available due to budget neutrality requirements.	42 CFR Chapter IV, Subchapter B §414.1310
Patient-Threshold Requirements for CMS High-Value Care Models	Arbitrary minimum patient numbers eliminate smaller, non-urban practices from participation in CMS high-value care programs.	CMMI models: Request for Application
Telehealth Prescription of Controlled Medication	Expiring flexibilities for telehealth prescriptions of controlled medications will burden patients and providers.	42 CFR Part 12 Chapter II § 1307.41
Excessive Penalties for Information Blocking	ONC's final rule implementing penalties under the 21st Century Cures Act could impose significant fines on providers found to engage in information blocking.	45 CFR Part 171; RIN 0955–AA05; 21st Century Cures Act
Face-to-Face Requirements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	Unclear Medicare rules for durable medical equipment cause administrative burdens and care delays.	42 CFR 410.38(d)(2)
DMEPOS Written Order/ Prescription	Documentation requirements for durable medical equipment orders add unnecessary burdens.	42 CFR 410.38(d)(1)
Home Health Services Timeframe Requirements	Rescheduling visits requires physician permission, creating administrative burdens.	42 CFR 424.22(b)(1)
Skilled Nursing Facility 3-Day Rule	Requirement for a 3-consecutive-day inpatient hospital stay prevents transitions to appropriate care settings.	Section 1861(i) of the Social Security Act and 42 CFR 409.30
Medicare Advantage Surveys	Patients need help understanding surveys, potentially leading to negative penalties for providers.	42 CFR 422.162(a) "CAHPS"
Dual-Special Needs Plans (D-SNP) Education for Providers	Redundant education requirements for providers increase administrative burdens.	42 CFR 422.107(c)
Documenting Suspect Conditions from Home Assessments	Inaccurate "suspect" conditions must be documented, potentially leading to care denials.	42 CFR 424.22(c)(1)
Preferred Provider List	Providing a list of preferred post-acute care facilities can improve patient outcomes and care coordination. This policy should be extended beyond the Next Generation ACO demonstration and apply to all providers in Medicare high-value care arrangements.	Next Generation ACO Demonstration

Support Practices Serving Rural and Underserved Populations in High-Value Care

AMGA Goal

Develop tailored support and incentives for small practices to participate in high-value care initiatives.

In 2021, the Centers for Medicare & Medicaid Services (CMS) announced its vision to have all Medicare beneficiaries in an accountable care relationship by 2030.[1] Under current policy, a lack of participation from small practices will prevent CMS from reaching this goal and, accordingly, prevent the patients served by these practices from experiencing the benefits of high-value care. AMGA recommends tailoring policies for smaller practices, those in rural areas, and those caring for underserved populations to ensure a successful transition to value.

While such practices serve populations well positioned to benefit from high-value care, there are a number of barriers preventing these providers from making the transition to value. In the context of the Medicare Access and CHIP Reauthorization Act (MACRA), small, rural, or underserved practices and individual providers largely have been exempt from the Merit-Based Incentive Payment System (MIPS). We cannot leave behind small and rural practices, as well as those caring for underserved patients in either the fee-for-service system or high-value care models.

To ensure all Medicare beneficiaries benefit from high-value care, CMS must develop tailored support and incentives for such practices to participate in high-value care initiatives rather than exempting them.

AMGA recommends Congress:

- **Create CMS regional hubs for small and underserved practices**: CMS regional hubs can create a networked environment where small practices share best practices, pool resources, and learn to thrive in the evolving healthcare landscape.
- **Scale models and strategies to align with the needs of small practices**: Models need straightforward pathways for small practices to progress toward higher levels of high-value care participation through reduced risk, standardized performance metrics, and predictable timelines.
- **Adopt a phased approach for practices in rural and other underserved areas**: Small and rural participants should be given a ramp-up period during which they are not exposed to downside risk.

Small and underserved practices face unique barriers to participating in high-value care arrangements. Transitioning to high-value care requires significant upfront investments of both money and staff time. Without access to economies of scale, it can be difficult for such providers to make these investments. Unlike larger systems, which can devote entire teams to high-value care, these practices often lack the staff necessary to evaluate high-value care model options. This barrier is magnified for practices serving disadvantaged populations.

1. https://www.cms.gov/priorities/innovation/about/strategic-direction#:~:text=All%20Medicare%20fee%2Dfor%2Dservice,cost%20of%20care%20by%202030.

Rural practices face additional challenges. These providers are often the sole source of care for their communities and must provide essential services without having the patient volumes to sustain such services. Existing policies, such as cost-based reimbursement for critical access hospitals (CAHs), account for the unique nature of rural providers, but they make integration with high-value care models more complicated.

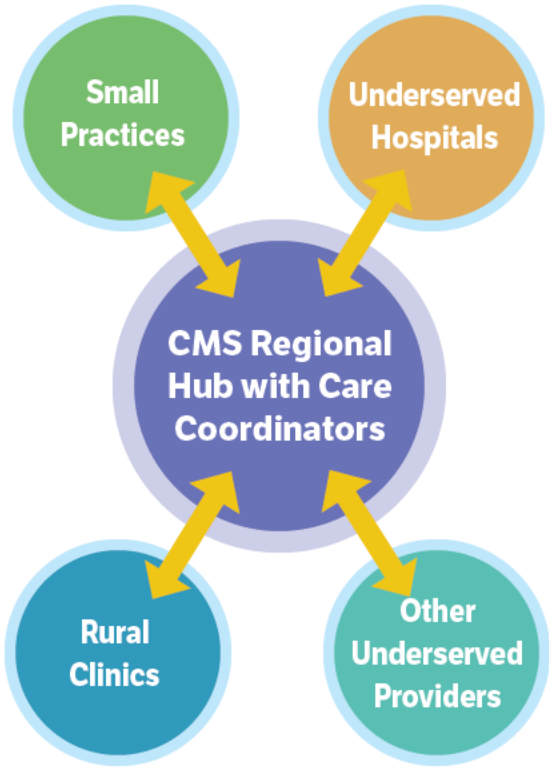
> *"The last few years we've been prevented from participating in the Medicare value models because our number of beneficiaries fell below the arbitrary 5,000 requirement. We haven't been able to get other small practices to join in with us as an ACO, likely because they haven't had to move into any type of value or MIPS process."*
>
> — **Dan Duncanson, MD**, *CEO, SIMEDHealth, LLC*

Create CMS regional hubs for small and underserved practices

AMGA recommends CMS create, develop, and manage regional hubs. These hubs can play a pivotal role in supporting small medical practices as they navigate high-value care models and fee-for-service programs like MIPS. While some advocate for permanently exempting small practices from MIPS due to their limited resources, doing so would risk depriving these practices and their patients of the benefits of improved care quality and value. Regional hubs can provide tailored support to small practices, helping them adapt to high-value care requirements and meet MIPS performance metrics. Support includes centralized services such as data analytics, care coordination training, and assistance with quality reporting, all designed to minimize administrative burdens and enhance outcomes. Small practices can use these resources to build the skills and infrastructure necessary to succeed in high-value care environments without being excluded from programs designed to promote quality and accountability.

Smaller practices face structural barriers to implementing high-value care caused by their patients' social drivers of health, such as serving patients in remote geographic locations or with limited access to technology. Encouraging collaboration could help mitigate these barriers by allowing providers to share success stories and improve feedback to CMS on how to better account for these social drivers through their models.

By fostering collaboration, CMS regional hubs can create a networked environment where small practices share best



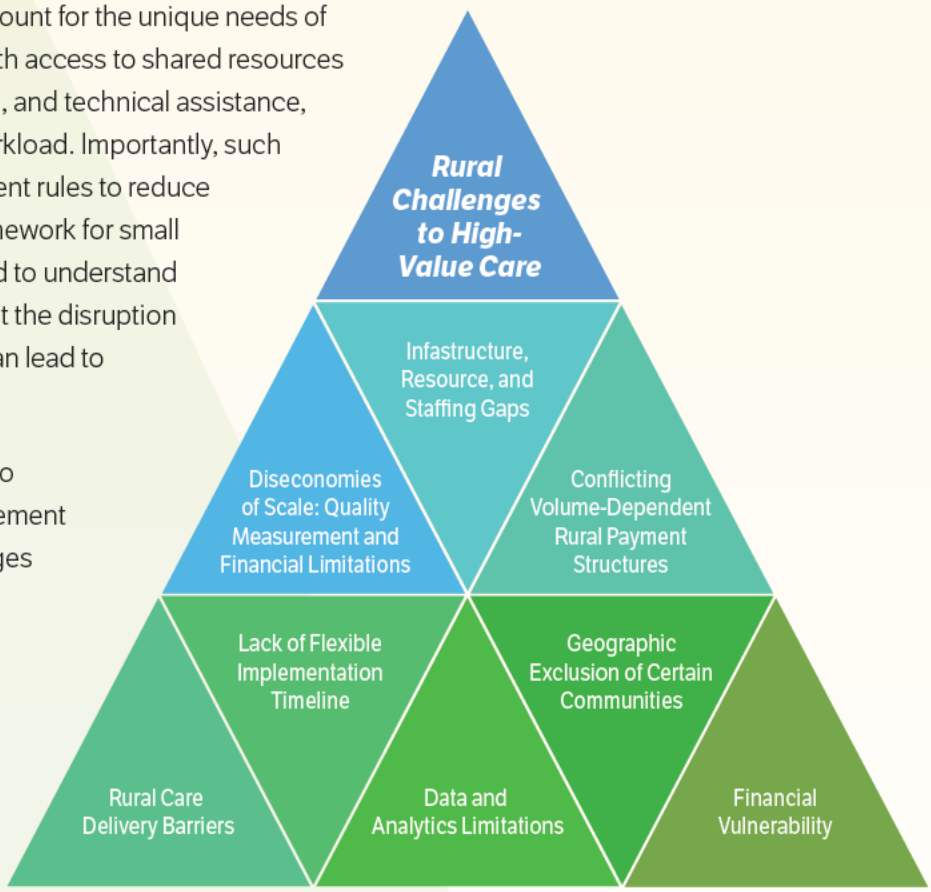
Regional hubs provide tailored support to underserved and rural practices, including centralized services such as data analytics, care coordination training, and assistance with quality reporting.

practices, pool resources, and learn to thrive in the evolving healthcare landscape. This collective support empowers practices to enhance patient care while gaining the experience needed to participate in broader high-value care initiatives. Additionally, ensuring that small practices participate in programs like MIPS encourages them to adopt patient-centered strategies, improving care access and outcomes for their patients. Rather than exempting these practices, CMS and Congress should prioritize investments in regional hubs to provide the tools and knowledge small practices need to deliver high-quality care while holding them accountable to the same standards as larger providers.

Such regional hubs also help address staffing challenges. For example, while a small practice could struggle to find the staff necessary to navigate a new model, multiple practices collaborating through a regional hub could share staff dedicated to high-value care programs.

Scale models and strategies to align with the needs of small practices

Small practices are a critical component of the healthcare system, but many face significant challenges in participating in high-value care models due to limited resources and administrative capacity. Scalable models specifically designed for smaller practices are essential to ensure their successful integration into high-value care initiatives. These models should account for the unique needs of smaller practices, providing them with access to shared resources like care coordination, data analytics, and technical assistance, while maintaining a manageable workload. Importantly, such models must have clear and consistent rules to reduce complexity and provide a stable framework for small practices to succeed. Practices need to understand the expectations and metrics without the disruption of frequent policy changes, which can lead to confusion and inefficiency.



Consistency in model design is key to fostering trust and long-term engagement from such practices. Frequent changes in requirements or benchmarks can discourage participation, as small practices may lack the infrastructure to adapt rapidly. These practices also are more vulnerable to swings in results associated with random variation and chance. Scalable models should establish straightforward pathways for small practices to progress toward higher levels of high-value care participation while aligning with Medicare goals. For example, shared-savings models with reduced risk, standardized performance metrics, and predictable timelines can encourage small practices to adopt high-value care strategies. By designing these models to scale according to practice size and capacity, CMS and Congress can promote widespread participation in high-value care, ensuring that all patients, regardless of where they receive care, benefit from improved quality and efficiency.

Adopt a phased approach for practices in rural and underserved areas

All practices, regardless of size or location, should be provided with the necessary support and resources to participate in high-value care. For small practices, this includes a phased approach that allows providers to ease into value without taking on overwhelming risk. Small and rural participants should be given a ramp-up period during which they are not exposed to downside risk. An example of this is the Transforming Episode Accountability Model (TEAM), which offers all participants the option to participate in an upside-only track in year one of the model. In response to comments from numerous stakeholders including AMGA, CMS will also allow safety-net providers to remain in this downside-risk-free track for three years. This will allow these hospitals time to understand the model and high-value care in general before taking on the risk associated with TEAM.

A successful transition to high-value care requires opportunities for all providers to participate in value-based programs. However, many current models impose minimum size or volume requirements that exclude smaller practices. For example, the MIPS low volume threshold excludes providers who do not meet specific thresholds for Part B allowed charges, patients seen, or number of services provided.[2] While eligible clinicians may opt-in to MIPS if they meet at least one criterion, many are exempt from participation. For 2025, CMS estimates that 129,806 clinicians will be prevented from participating in MIPS due to this threshold.[3]

While these thresholds are intended to protect smaller practices from the challenges of complex programs, there are better options than exclusion. Targeted assistance, reduced administrative burdens, or mitigated risk for smaller providers can help them succeed in high-value care programs. As previously noted, TEAM offers "vulnerable" participants serving safety-net populations protection from downside risk during the first three years of the model,[4] allowing a more manageable transition. By contrast, small practices excluded from MIPS will not advance and learn to deliver care under more modern models if they are never expected to participate.

High-value care models should not exclude providers simply because of their size or risk. Instead, policymakers should support CMS in developing solutions that enable these providers to thrive within the value-based framework.

This easing into risk is especially critical given the lack of data around how small practices perform in high-value care models. One of the stated reasons for implementing TEAM was to "better understand the

Case Study:

Building Toward Risk

"We were a small-sized ACO, and a new entry into high-value care when we became a 2012 MSSP. Through our 6 years in the MSSP program, we created savings for Medicare in 4 of the 6 years, but only crossed the sharing threshold in our last year. Despite the very delayed return on our investment of resources into the MSSP, we improved quality and risk adjustment scores year-over-year and saw significant gains in total costs of care versus our peers. These adjustments in our approach to care resulted in terrific ROIs for our high-value care efforts with MA plan and commercial payer arrangements. Had we never started down the MSSP path, it is doubtful we would have put in the effort necessary to create these behavior changes."

— **Dan Duncanson, MD**, *CEO, SIMEDHealth, LLC*

2. https://qpp.cms.gov/mips/how-eligibility-is-determined
3. 89 FR 62189
4. 89 FR 69661

impact of a model on a broader range of hospital types, beneficiaries, and communities that are not usually included in a voluntary model." Small practices and hospitals play a critical role in providing care to their communities and should not be exposed to high levels of risk until its impact is better understood.

Another way to help small practices transition to value is to help them cover the upfront costs of this transition. For example, Medicare Shared Savings Program (MSSP) Advanced Investment Payments (AIP) provides advanced payments to providers to help them cover the costs of building the infrastructure necessary to form accountable care organizations (ACOs).

Conclusion

The healthcare system is not on track to fulfill CMS' vision of all Medicare beneficiaries being involved in an accountable care relationship by 2030. To meet this goal, policymakers must remove barriers preventing all practices and hospitals from participating in high-value care. Doing so will bring considerable benefits to the vulnerable populations served by these providers, who are well-suited to benefit from high-value care. For example, rural populations face higher rates of a number of chronic diseases, including diabetes and heart disease,[5] and are more likely to die from cancer than their urban counterparts. By incentivizing proactive treatment, high-value care would help rural patients better avoid or manage these diseases. Providers at small practices also regularly utilize the skills necessary to succeed in high-value care models, which emphasize accomplishing better health outcomes with fewer resources and building relationships with patients. By creating a supportive policy framework, Congress and CMS can empower these providers to benefit from high-value care while serving their communities.

5. Coughlin SS, Clary C, Johnson JA, Berman A, Heboyan V, Benevides T, Moore J, George V. Continuing Challenges in Rural Health in the United States. J Environ Health Sci. 2019;5(2):90-92. Epub 2019 Dec 16. PMID: 32104722; PMCID: PMC7043306.

Ensure the Long-Term Sustainability of High-Value Care

AMGA Goal

Increase support and participation in high-value care by ensuring adequate Medicare reimbursement that considers the total and ongoing costs of providing care.

In 2021, CMS set an ambitious goal to have all Medicare beneficiaries in an accountable care relationship by 2030.[1] AMGA applauds this goal, but recognizes that the transition will only be successful if supported by a predictable, stable, Medicare reimbursement system that enables clinicians to meet the needs of an aging population.

The current Medicare Part B reimbursement system plays a crucial role in supporting patient access, but fails to adequately account for rising operational costs. Without an inflation-adjusted payment system, providers face mounting financial pressure, which threatens access to care, quality, and long-term sustainability. Just as other essential sectors adjust for inflation, Medicare Part B reimbursement must reflect the real costs of labor, technology, and medical supplies to avoid potential service reductions or closures.

In addition, evaluating Medicare Part B costs without considering downstream savings in Medicare Part A spending presents a narrow and fragmented view of healthcare expenses. Investments in outpatient and preventative services can offset costly hospitalizations; however, current policy does not fully account for this dynamic.

Finally, for high-value care models to succeed, providers need regulatory stability throughout the program agreement period to effectively plan and implement strategies to improve patient outcomes while managing costs. Frequent changes to program rules or payment methodologies create uncertainty and undermine long-term investments in care coordination, technology, and preventive services.

Why High-Value Care?

High-value care rewards providers based on patient health outcomes rather than the volume of services delivered and promotes team-based care, an approach that is well-suited to address health inequities and manage chronic conditions.

Given that nonmedical factors are estimated to account for 80% of a population's health and that approximately 94.9% of Americans aged 60 or older have at least one chronic condition, the ability of high-value care to incentivize better outcomes in addressing health inequities and chronic conditions will be crucial in controlling long-term healthcare costs.

With the U.S. population rapidly aging—every baby boomer will be eligible for Medicare by 2030—and healthcare workforce shortages are expected to persist into the 2030s, controlling these costs will be essential in maintaining access to high-quality care for elderly Americans.

1. https://www.cms.gov/priorities/innovation/about/strategic-direction#:~:text=All%20Medicare%20fee%2Dfor%2Dservice,cost%20of%20care%20by%202030.

To support clinicians under traditional fee-for-service Medicare and facilitate the shift to high-value care, AMGA recommends that Congress:

- **Establish a baseline inflationary adjustment based on the Medicare Economic Index (MEI) as part of the annual Medicare Physician Fee Schedule (MPFS) reimbursement update**: The gap between clinician reimbursement and the cost of providing care has continued to grow. This must be addressed by including an inflationary update in the MPFS, as similarly recommended by the Medicare Payment Advisory Commission (MedPAC).[2]
- **Increase or eliminate the MPFS budget neutrality threshold**: Budget neutrality requirements, including the spending cap on new services, should be updated to reduce disproportionate impacts on providers; or eliminate this requirement to better align the Part B reimbursement system with the other components of Medicare.
- **Eliminate exclusions from the Merit-Based Incentive Payment System (MIPS)**: The low-volume threshold undermines the program's ability to drive quality and value.
- **Ensure model stability in high-value care arrangements**: Avoid mid-contract changes to model terms that deter provider participation in risk-based models.
- **Recognize Part A savings in Part B reimbursement decisions**: Congress should consider the full picture of Medicare costs and savings when evaluating outpatient services.

What is included in Medicare Part B?

Medicare Part B covers medically necessary and preventive services, including physician office visits, outpatient care, lab tests, durable medical equipment, and some home health services.

Part B also pays for services like chemotherapy, dialysis, and mental health care.

Medicare Part B does not cover physician compensation itself—rather, it reimburses for services rendered based on the MPFS, which determines payment rates for covered procedures and visits.

Establish a baseline inflationary adjustment based on the Medicare Economic Index (MEI) as part of the annual Medicare Physician Fee Schedule (MPFS) reimbursement update

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) was intended to establish a predictable and supportive framework to help providers transition to high-value care. Central to this framework were up-front incentives and stable financing, particularly through participation in Advanced Alternative Payment Models (APMs). However, MACRA was not designed to account for unforeseen disruptions like the COVID-19 public health emergency (PHE), which delayed many providers' transitions to value. Despite these delays, the time-limited bonuses designed to encourage participation in APMs have not been extended to reflect this enormous setback. Instead, Congress has enacted a series of short-term legislative fixes to prevent Medicare reimbursement cuts, offering temporary relief but little long-term stability.

Critically, MACRA fails to link clinician payment to inflation. Unlike other components of Medicare, Part B lacks an automatic update tied to broader inflation metrics, such as the Consumer Price Index (CPI) or Producer Price Index (PPI). This disconnect leads to reimbursement rates that have not kept pace with real-world costs of medical supplies,

2. March 2025 Report to the Congress: Medicare Payment Policy, MedPAC March 13, 2025

technology, and staff salaries—all resulting in financial strain on ambulatory providers. Congressional interventions, while helpful, have done little to close the widening gap between clinician payments and the total cost of providing care.

For example, the Consolidated Appropriations Act of 2024 (CAA, 2024) provided partial relief for the 2024 MPFS, but was not enacted until March. This delay caused Part B providers to absorb lower reimbursements for the first quarter of 2024. Even when Congressional relief arrived, the 2024 conversion factor decreased 1.77% from the previous year. This is part of a broader downward trend since MACRA went into effect in 2015, with an overall decrease from $35.75 in 2015 to $32.34 in 2025 (Figure 1). Over the same period, the cost of operating a medical practice has increased by roughly 20%.[3]

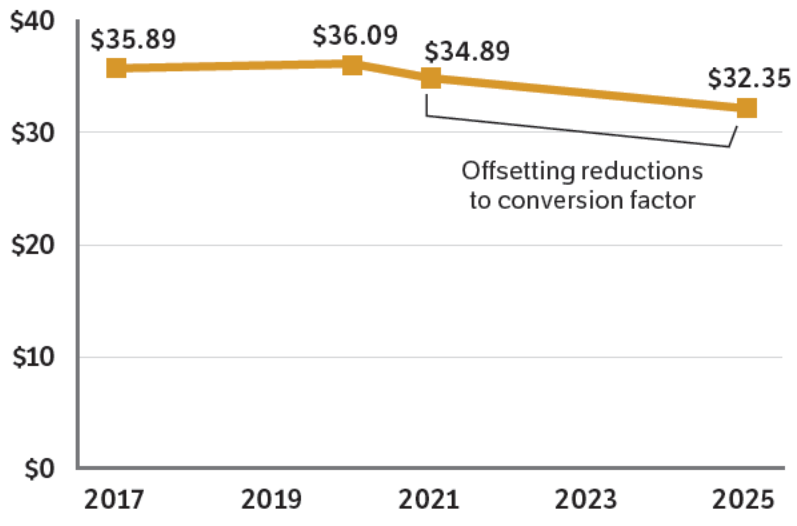
This chronic lack of investment in ambulatory clinician services deprioritizes one of the most cost-effective ways to improve Medicare beneficiaries' health. Regular office visits, chronic disease management, and preventative care can help patients avoid costly hospitalizations and complications, yet the payment system does not reflect or reward this value.

Looking ahead, the gap between clinician reimbursement and the cost of providing care is projected to widen. The Centers for Medicare & Medicaid Services (CMS) estimates the MEI will increase by an average of 2.3% annually from 2025 to 2033 (Figure 2).[4] However, under existing legislation, clinician reimbursement remained flat in 2025, and will only rise by 0.75% per year for Advanced APM participants and 0.25% for all other clinicians in 2026 and beyond. This represents a sharp downturn from the modest bonuses (between 5% and

"Budget forecasts for investments in the technology, personnel, and infrastructure necessary to build and sustain an accountable care organization (ACO) are done so on a multiyear timeframe. Part of that budgeting includes the projected revenue return from those investments in the form of shared savings or premium dollars. Uncertainty over the Medicare conversion factor and other payment mechanisms leads to reluctance to make these investments in the transition from fee-for-service to high-value care."

— **Dr. Alka Atal-Barrio, MD, FAAP, MMM**, *National Senior Medical Director, Optum Health and Optum West*

Figure 1. Conversion Factor Reduction 2017–2025

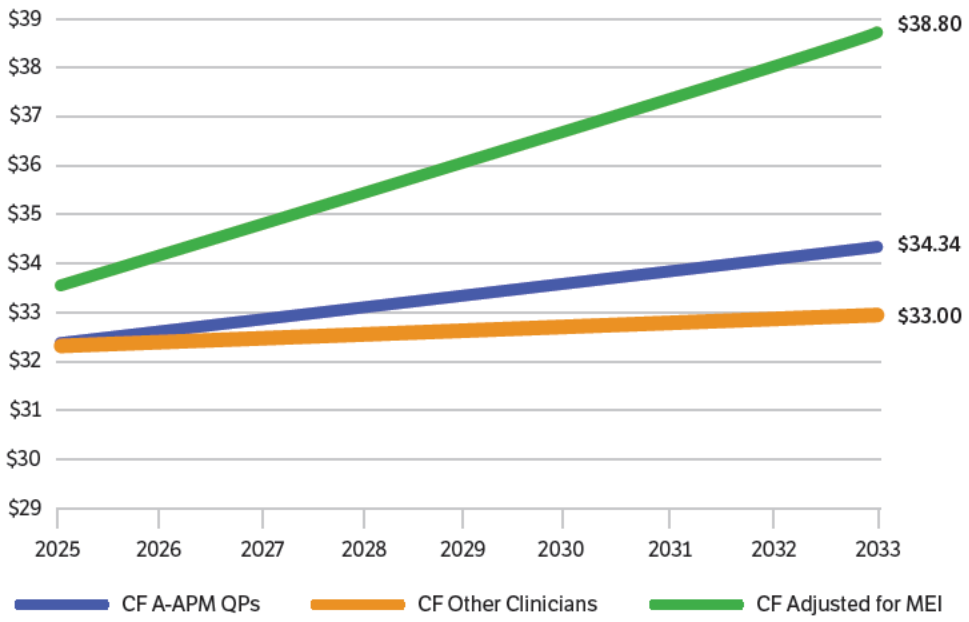


3. Source: Market Basket Update from 2016 – 2024 Actual Regulation Market Basket Update
4. https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_Ch1_MedPAC_Report_To_Congress_SEC.pdf

1.88% annually), that Congress created for Advanced APMs from 2017 to 2024.

Without meaningful reform, the trajectory of Medicare reimbursement for Part B providers will continue to erode participation, strain practice sustainability, and undermine the shift to high-value care.

Figure 2. Conversion Factor Updates Under MACRA 2025+ Compared to CMS MEI Projections



Increase or eliminate the MPFS budget neutrality threshold

The Medicare Part B reimbursement system is constrained by outdated budget neutrality requirements, which mandate offsetting reductions to clinician payments if any policy change increases projected spending by more than $20 million in a given year. This threshold, set in 1992, has never been adjusted for inflation or changes in the scope of Medicare services.[5]

While originally intended to control spending, budget neutrality often creates unintended consequences that disproportionately affect providers. When new services, such as advanced diagnostic tools or telehealth options, are added or updated, payment reductions are applied across all services—regardless of their actual cost or value. This results in an inequitable system in which certain providers, especially those offering primary or preventive care, face significant financial strain. These across-the-board reductions often hit primary and preventive care providers the hardest, creating disincentives to offer essential but lower-margin services.

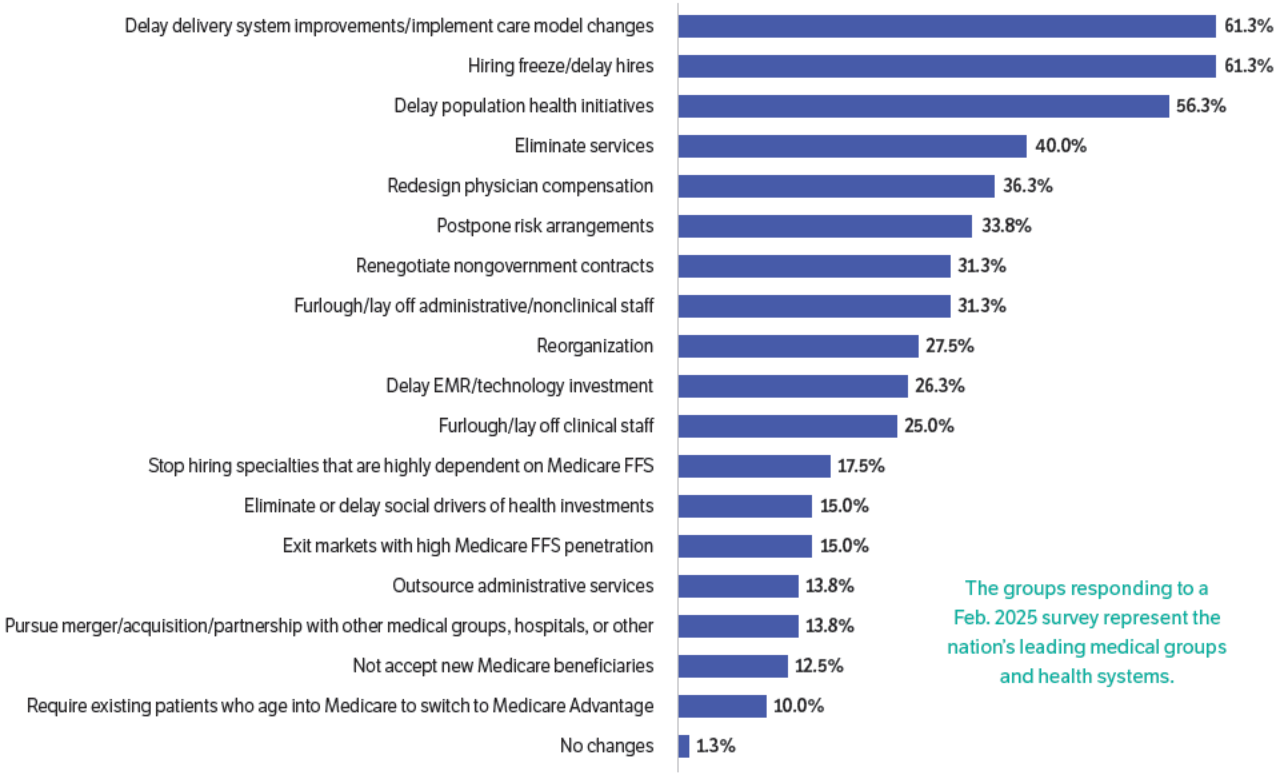
These policies have had significant impacts on AMGA members and their patients. In a recent survey conducted after the January 2025 conversion factor cut, 40% of respondents reported eliminating services to Medicare patients. Another 25% of respondents furloughed or laid off clinical staff, and 31% furloughed or laid off nonclinical staff. Thirteen percent of survey respondents reported they are no longer accepting new Medicare patients in 2025 (Figure 3). If current trends continue, access and workforce challenges will only worsen.

"Preventative health is best provided by medical professionals outside of hospitals and the emergency room. Despite this, independent practitioners are being forced to close because of reimbursement cuts and inflating practice expenses."

— **Scott Barlow**, *CEO, Revere Health*

5. https://bucshon.house.gov/news/documentsingle.aspx?DocumentID=4467

Figure 3. AMGA Survey on Actions Taken Due to 2025 MPFS Conversion Factor Decrease



Eliminate exclusions from MIPS

AMGA has long raised concerns that the Merit-Based Incentive Payment System (MIPS) is undercut by overly broad exemptions, especially the low-volume threshold, which precludes a significant number of clinicians from participation. These exclusions undermine the program's goals of improving quality and prevents high-performing providers from receiving meaningful payment adjustments. As detailed in Chapter 5, "Support Practices Serving Rural and Underserved Populations in High-Value Care," AMGA supports policies that ensure all providers engage in performance measurement and reporting. This would create a more comprehensive and equitable system for evaluating and improving care. Rather than broad exclusions, CMS should offer resources and tailored support, such as technical assistance and scalable models, as well as performance feedback tailored to small practices and low-volume providers. Simply put, exempting providers from MIPS undermines the integrity of MACRA and the broader transition to high-value care.

Ensure model stability in high-value care arrangements

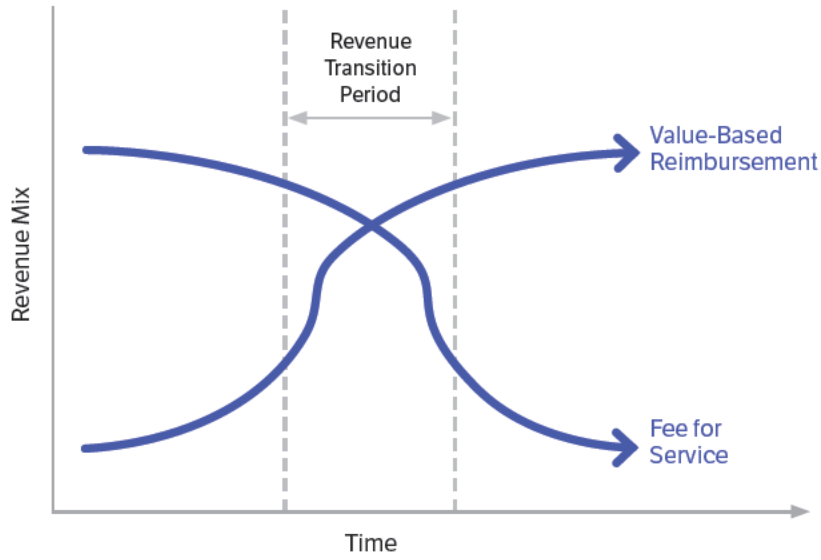
Achieving the long-term benefits of high-value care requires providers make upfront investments in staffing, care redesign, infrastructure, and cultural transformation within the practice. These changes demand both time and financial resources, which for most providers requires a predictable operating environment. To successfully transition to value, providers must allocate time to understanding value-based programs, forecast performance, implement the necessary initiatives for participation, and transition to team-based care models. This requires a shift in provider mindset and behaviors to prioritize patient-centered care and coordinated treatment plans. In addition, holding

providers accountable for the quality and cost of beneficiary care demands financial risk, which requires payment stability. Even in one-sided or upside-only models, upfront investments can be significant. Given the instability of the Part B reimbursement environment, providers lack both stable financing and the capital needed to make the transition to high-value care.

As high-value care represents a fundamental transformation away from the traditional fee-for-service system, providers must be given adequate financial stability to support the transition. This should include a phased revenue transition period (Figure 4).[6]

Mid-agreement changes to model rules are a major source of contention, especially those impacting financial elements such as risk adjustment. These changes have historically disrupted provider confidence in high-value care and discouraged participation. Unlike mandatory models, voluntary models do not allow participants to provide feedback on mid-model changes through notice and comment periods.

Figure 4. Proposed Revenue Transition Period from FFS to High-Value Care



For instance, the recent change in coding methodology for the MSSP from the 2020 CMS-Hierarchical Condition Category (HCC) model to the updated 2024 CMS-HCC model has required Accountable Care Organizations (ACOs) to revise their coding guidelines, retrain staff to ensure compliance, and adjust their financial forecasts. Similarly, in December 2017, CMS introduced a new risk adjustment factor in the Next Generation ACO Model, which reduced the average risk score by 4.82%, making it significantly harder for providers to achieve profitability under the program. Although the change was announced on December 7, 2017, it was retroactive to payments for the entire year, significantly impairing providers' ability to achieve shared savings.

Similarly, the implementation of new mandatory models must allow providers sufficient time to prepare. Transitioning from fee-for-service to an accountable care model requires operational changes within individual practices and across the broader care continuum. For example, CMS' recently finalized Transforming Episode Accountability Model (TEAM) holds hospitals accountable for most medical spending following select surgical procedures, including services outside of the hospital's direct control, such as post-acute care or physical therapy.

To succeed under TEAM, participants will need time to accurately forecast the costs incurred at their own facilities and at partner facilities and provider groups. This may involve negotiating new or updated agreements and establishing

6. Graph taken from https://www.healthcatalyst.com/learn/insights/hospital-transitioning-fee-for-service-value-based-reimbursements

new care coordination protocols with these partners. CMS has allotted 17 months of pre-implementation preparation time, followed by a 12-month performance period without downside financial risk.[7] While AMGA has significant concerns about the feasibility of generating savings under TEAM, we appreciate the extended runway, which is essential for enabling providers to adapt their operations, build collaborative networks, and effectively manage episode-based care.

Recognize Part A savings in Part B reimbursement decisions

Underfunding Medicare Part B services to control short-term spending overlooks the long-term cost-savings achievable under Part A through innovations in care delivery. Since the COVID-19 PHE, tools like remote patient monitoring and telehealth visits have grown exponentially, enhancing access to care for patients (particularly in rural or underserved areas) and helping them prevent avoidable complications. Modest investments in preventive and outpatient care can result in significant savings by reducing hospital admissions, readmissions, and extended inpatient care covered by Part A.

However, Medicare's current reimbursement policies do not recognize these downstream benefits. To address this, CMS should adopt an integrated approach that aligns financial incentives across Parts A and B. This includes considering projected Part A savings when setting Part B payment rates and encouraging a shift toward high-value care models that reward prevention and early intervention. This approach would not only reduce overall program costs, but also improve patient outcomes by fostering proactive, rather than reactive, care delivery.

Conclusion

Transitioning the American healthcare system to high-value care is crucial for maintaining access to high-quality care and improving health outcomes for Americans. High-value care incentivizes preventative care and enhances coordination across a patient's care team—key strategies for managing chronic conditions and avoiding costly interventions. As the U.S. population ages and widespread healthcare workforce shortages persist, maximizing the efficiency and effectiveness of healthcare delivery through high-value care is increasingly urgent.

For providers to lead this transition, they must have the ability to fund upfront investments. This requires a reliable fee-for-service foundation and assurance that high-value care program rules will not change during the agreement period. Key policy changes—such as linking clinician payment to the MEI, extending Advanced APM bonuses, and ensuring that providers have sufficient time to adapt to new model rules—would create an optimal environment for the high-value care transition. This stability will help prepare the American healthcare system to address the demographic and financial challenges ahead.

Absent these reforms, it will be increasingly difficult for providers—especially those in smaller and under-resourced practices—to bear the risks or costs of transformation. Instead of advancing toward value, they may be forced to freeze hiring, reduce staff, cut population health initiatives, scale back investments in certain programs, or limit services for Medicare beneficiaries. Recognizing the gravity of these consequences, Congress must act to modernize the Medicare physician payment system to support providers in the transition to high-value care.

7. 36 months for participants that qualify as "safety-net" under TEAM.

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Acknowledgments

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Statement of the American College of Surgeons
to the Committee on Energy & Commerce
Subcommittee on Health
United States House of Representatives
RE: Examining the Medicare Physician Fee Schedule, MACRA,
and Opportunities for Payment Reforms
May 20, 2026

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On behalf of the more than 96,000 members of the American College of Surgeons (ACS), thank you for convening the hearing, "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms." The ACS remains committed to ensuring the highest quality of care for all surgical patients, including Medicare beneficiaries, and we appreciate the opportunity to discuss some areas within the Medicare reimbursement system that could be improved in order to ensure access to high-quality surgical care for all American seniors.

We thank Congress for its efforts to address short-term instability in the Medicare Physician Fee Schedule (MPFS) over the last few years, as well as the Health Subcommittee's attention to broader reform of the Medicare Access and CHIP Reauthorize Act (MACRA). Federal policy should enable surgeons of all specialties, in all practice settings, and in all career stages, to provide the best possible care for their patients while leading full and productive personal and professional lives. The ACS is committed to working with Congress to stabilize the physician fee schedule as well as reform MACRA to better realize the goal of value-based care.

Identifying Structural Problems Within the Medicare Physician Payment System

Quality has been the cornerstone of the ACS since its founding more than 110 years ago, and the ACS continues to provide accreditation and verification programs, products, guidelines, and tools to improve surgical quality. But optimal quality, the centerpiece of the ACS' mission, is not achievable without optimal access. Unfortunately, recent regulatory changes to the MPFS have systematically devalued surgical care, threatening patient access to critical services. In addition, long-term structural challenges persist within the payment system and with implementation of MACRA.

Instability within the MPFS threatens the viability of physician practices and erodes quality improvement efforts. Over the last few decades, Centers for Medicare & Medicaid Services (CMS) policies have resulted in broad and arbitrary cuts, repeatedly to the MPFS conversion factor, and more recently, to the work Relative Value Units (RVUs) and intra-service time for all non-time-based codes. These repeated cuts are often an unintended consequence of statutory budget neutrality requirements of the MPFS, which pit physicians against one another as resources must be taken away from certain physician services to finance others.

A zero-sum payment system is counterproductive as it forces all specialties to compete for increasingly scarce resources while failing to incentivize high-quality care or effective care coordination. The ACS is grateful to Congress for mitigating recent cuts by providing 2.5% conversion factor relief for 2026 as part of H.R. 1. However, if Congress does not act, this one-time fix will expire at the end of the year and create yet another cut to reimbursement on January 1, 2027.

Moreover, the MPFS remains the only Medicare payment system that is not indexed for inflation. Physicians saw their Medicare reimbursement decrease by 15.5% in real terms between 2001 and 2025 while practice expenses such as rent, equipment, staffing, and utilities have increased. Surgeons and other physicians have also seen an increase in financial pressures to meet new bureaucratic barriers such as increased use of prior authorization in Medicare Advantage.

In addition to these financial pressures, failures in the implementation of MACRA have hindered the transition to value-based care. Since the enactment of MACRA in 2015, the ACS has made significant investments to translate what we have learned about improving quality of care and outcomes into proposals to increase value for surgical patients. Our efforts have included:

- Early leadership and ongoing work in surgical alternative payment model (APM) development, including submission of one of the first Advanced APM proposals to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The ACS has continued to offer constructive feedback and advice to CMS and the Center for Medicare and Medicaid Innovation (CMMI) on how best to accommodate specialists eager to participate in value-based care;

- Development of the CMS *Age-Friendly Hospital Measure*, a novel programmatic quality measure finalized in the CMS Inpatient Quality Reporting (IQR) program that incentivizes patient-centered, goal-concordant, team-based care organized around the geriatric hospital patient; and

- Development of the *ACS CollaboRATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients* measure to assess the quality of patients' shared decision-making for surgery in the ambulatory setting to improve patient-centricity, patient outcomes, and unnecessary care.

Yet today, many surgeons still struggle with the same barriers to improving outcomes and transitioning to modern payment systems that they did a decade ago:

- Surgeons were faced with a 2.5% reduction to work RVUs in 2026 in addition to reductions in facility-based practice expense RVUs earned for procedures performed outside an office setting;

- The combined effect of inflation and the absence of physician fee schedule updates to reflect rising practice costs has made care more expensive to deliver even as payment rates continue to decline;

- Most physicians in fee-for-service (FFS) are still evaluated based on measures that do not assess care delivered to their patients or the conditions they treat, meaning no information is available for improvement efforts or for patients and referring physicians to make care choices; and

- Many surgeons wishing to move beyond FFS will find few physician-focused APMs are available for them. Current options are largely mandatory and some limit the ability of interested parties to opt-in. This is compounded by the failure to test voluntary, physician-directed models approved by the PTAC.

MACRA was intended to fix problems in the previous reimbursement landscape and transition to a value-based care system. However, many structural barriers remain. Under current law, and assuming no additional cuts result from budget neutrality or other policy decisions, it would take decades for the MPFS conversion factor to return to the same amount it was in the year 2000. Over that same period, inflation will have significantly eroded the value of payments. Clearly, this is not tenable. The ACS is concerned that ongoing systemic challenges, coupled with the persistent devaluation of surgery within the MPFS, will jeopardize access to surgical services in the future.

I. Addressing the Devaluation of Surgical Care

Stop Implementation of CMS' Flawed Efficiency Adjustment

In order to ensure that Medicare patients maintain access to the full spectrum of health care services, Congress must first address the recent cuts to procedural codes that took effect January 1, 2026. This most recent cut disproportionally affects surgical and other procedural specialties and illustrates the broader structural issues that force physicians to fight over limited resources.

The latest action by CMS reduces the work RVUs and intra-service time for all non-time-based codes by 2.5% in 2026, with additional reductions expected every three years indefinitely. This "efficiency adjustment" is intended to address an incorrect assumption that non-time-based services become more efficient as the services become "more common, professionals gain more experience, technology is improved, and other operational improvements are implemented."[1] In direct contradiction to this claim, a recent peer reviewed study published in the *Journal of the American College of Surgeons* analyzing more than 1.7 million operations, spanning 249 CPT codes and 11 surgical specialties, found that 90% of CPT codes had the same or longer operative times in 2023 compared to 2019.[2]

The policy from CMS assumes longitudinal efficiency for an individual physician and proposes the adjustment be applied in a cross-sectional manner to all non-time-based codes, including those that have been recently revalued. Adding to the flawed implementation of this policy, the 2.5% reduction was calculated using only the productivity component of the Medicare Economic Index (MEI), which is not a valid measurement of physician-specific productivity, given that the MEI is based on changes in economy-wide productivity and does not reflect physician work. While the MEI could be useful in accounting for the rising cost of care delivery, unfortunately, there is no automatic inflationary adjustment to account for these increased costs, based on MEI or otherwise, included in the MPFS, and the productivity component of the MEI on its own is meaningless.

This policy is based on the premise that services will continue to become more efficient indefinitely, and that all physicians experience the same rate of efficiency, which is flawed. While advances in medical technology and treatment protocols allow more patients to survive severe illnesses, these same patients often later require complex, high-risk procedural intervention. Highly experienced physicians may improve time efficiency, but undertake the most challenging cases, whereas newly trained or teaching physicians may treat less complicated patients but typically require more time. Valuation is based on time and complexity/intensity—not just time alone.

Further, a recurring reduction in work RVUs every three years will have severe consequences for physician compensation, even beyond direct reimbursement from the MPFS. Many physician employment contracts are based on work RVUs or total RVUs, meaning that reductions in these values will decrease physician compensation despite no reduction in actual work performed. The inability to anticipate the magnitude of RVU reductions introduces ongoing uncertainty, making it increasingly difficult to structure fair and sustainable employment agreements, while extending another layer of financial unpredictability for private practice and solo practitioners. The likely response to this instability may be further consolidation.

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[1] 90 FR 32352

[2] Childers CP, Foe LM, Mujumdar V, et al. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. *J Am Coll Surg*. 2025.

For surgeons, this efficiency adjustment is not a technical coding issue. It is a direct payment cut layered on top of years of instability in the MPFS. It will disproportionately affect procedural and surgical care, including general surgery, where Medicare payment reductions already threaten access in communities facing shortages. **The ACS is grateful to Representatives Ron Estes and Tom Suozzi for introducing H.R. 7520, the Efficiency Adjustment Delay Act, to stop this cut and require CMS to provide clinically relevant data before implementing a one-time efficiency adjustment in the future. We urge Congress to include this legislation in boarder Medicare payment reform proposals.**

Appropriately Value Surgical Global Codes

The recent reduction applied to procedural codes is compounded by years of declining value of surgical global codes. Global codes bundle preoperative, intraoperative, and postoperative care into a single payment, limiting separate reimbursement for related services. In the calendar year (CY) 2021 MPFS final rule, CMS increased the values for office and outpatient Evaluation and Management (E/M) visits but failed to apply corresponding adjustments to the E/M services included within global surgical codes.[3] Similarly, when the Agency approved increases to hospital inpatient and observation services for CY 2023, the corresponding adjustments within global surgical codes were not applied.

This deliberate departure from precedent in CYs 2021 and 2023 resulted in a disproportionate devaluation of global codes and created specialty-specific payment inequities that run contrary to Medicare statute. The ACS is concerned that by not incorporating this increased valuation of E/M codes into global surgical packages where similar services may be delivered as part of a patient's surgical case, the longitudinal care provided by surgeons is undervalued. **We continue to advocate for more accurate alignment between E/M valuation and the global codes to ensure high-quality surgical care is recognized.**

Reverse Facility-Based Practice Expense Changes

The CY 2026 MPFS final rule also included a reduction to indirect practice expense (PE) RVUs for facility-based services. This change is based on a flawed assumption that facility-based indirect PE payments may result in "double counting" when hospitals employ physicians, as some of these overhead costs may already be reflected in separate facility payments under the Outpatient Prospective Payment System. However, given that employed physicians never receive this facility fee, they are not the beneficiary of this perceived imbalance. Furthermore, CMS imposes this policy on all physician services furnished in the facility setting, regardless of the physician's employment status or practice structure. The result is a shift in reimbursement from the facility to the non-facility setting – estimated at -7% in facility settings and +4% in non-facility settings.

This change may result in increased payment for certain physicians billing office visits in the non-facility setting despite being employed by a hospital, in direct contradiction to CMS' stated intent. Additionally, it creates a perverse financial incentive for hospitals to consolidate by acquiring independent physician practices and shifting more services into the non-facility setting where higher payments may apply. Such a shift would accelerate the ongoing trend of market consolidation, reduce competition, and further inflate costs for patients. **The ACS believes that any savings CMS achieved by addressing perceived duplicate indirect PE payments should not be reallocated to non-facility PE RVUs. Instead, such savings should be redistributed via a budget neutrality adjustment to the MPFS conversion factor to**

[3] Childers CP, Hu CY, Swisher SG, Wong SL, Chang GJ. Estimated Financial Impact of 2021 Office-Visit Work Relative Unit Updates on Surgical Global Periods. *JAMA Surg*. 2024;159(9):1087-1089.

maintain relativity across all specialties and settings, rather than inflating payments selectively for non-facility services.

Medicare Reimbursement Has Declined and Practice Costs Have Risen

Recent Medicare reimbursement changes must be understood in the broader context of physician payment system instability. The MPFS conversion factor has declined over the last several years, even as the cost of running a surgical practice has increased.

Calendar year	Medicare Physician Fee Schedule conversion factor	Notes
2021	**$34.89**	Revised CY 2021 conversion factor after congressional action.
2022	**$34.61**	Updated CY 2022 conversion factor; lower than 2021.
2023	**$33.89**	Updated CY 2023 conversion factor after congressional relief.
2024	**$32.74 initially; later adjusted for part of the year**	CMS listed the CY 2024 conversion factor as $32.74 for Jan. 1–Mar. 8, with a later statutory update applying for Mar. 9–Dec. 31.
2025	**$32.35**	Final CY 2025 conversion factor.
2026	**$33.57 for qualifying APM participants; $33.40 for non-qualifying APM participants**	CMS finalized separate 2026 conversion factors under current law. The conversion factors increased due to *temporary c*ongressional relief, pre-existing statutory adjustments, and budget neutrality effects of the efficiency adjustment.

From 2021 to 2025, the conversion factor fell from $34.89 to $32.35, a decline of approximately 7.3%. Even with the 2026 statutory increase, the non-qualifying APM conversion factor of $33.40 remains about 4.3% below the 2021 level. And this increase masks reductions felt by many physician specialties affected by CMS policies including the efficiency adjustment.

That decline does not account for inflation, staff costs, rent, supplies, medical liability coverage, health information technology, compliance costs, or the cost of maintaining 24/7 surgical readiness. For general surgeons, who often provide emergency care, trauma coverage, endoscopy, abdominal surgery, cancer-related procedures, and essential backup for rural hospitals, this instability creates mounting pressure. Congress has repeatedly stepped in to mitigate scheduled cuts on a yearly basis, but temporary patches do not give surgical practices the predictability needed to recruit staff, maintain call coverage, invest in quality improvement, or remain financially viable in underserved communities.

II. Stabilizing Medicare Reimbursement

The ACS is committed to working together with Congress to ensure the stability of the MPFS through both short and long-term policy improvements. While 2026 is the first year where positive statutory updates are included in the MPFS, this positive adjustment is outweighed by years of devaluation. Current law provides a 0.25% conversion factor update for non-APM participants and a 0.75% update for qualified Advanced APM participants, still failing to adequately offset the effects of inflation and account for rising medical and staff costs. Without congressional action, continued cuts will challenge physicians to provide adequate services and high-quality care. Additionally, without an inflationary update for the MPFS, it is unlikely that future payments will keep pace with medical costs.

ACS supports building an update into the MPFS, comparable to other Medicare payment programs, to account for the effects of inflation on the cost of providing care to seniors as a starting point to create a more stable foundation for value-based care initiatives. This inflationary update should be separate and distinct from incentives for quality and from the budget-neutral Merit-based Incentive Payment System (MIPS) incentives. **One potential solution would be H.R. 6160, the Strengthening Medicare for Patients and Providers Act, introduced by Representatives Raul Ruiz, MD and Gus Bilirakis. This legislation would provide an inflationary update to the MPFS based on MEI.**

The impact of the lack of inflationary adjustments is further compounded by the overly strict nature of the budget neutrality trigger. The budget neutrality requirement in a system with no inflationary updates results in across-the-board cuts for any changes to the MPFS expected to increase expenditure by as little as $20 million annually. This trigger amount has remained the same since its implementation in 1992. Updating the trigger for budget neutrality adjustments would help to ensure that comparatively minor changes to relative values or the addition of limited new service codes do not always require across the board cuts. **Congress, at a minimum, should amend 42 USC 1395w-4 (c)(2)(B)(ii) to increase the current $20 million budget neutrality adjustment trigger and index it for inflation going forward**. **The ACS thanks Representative Greg Murphy, MD for introducing H.R. 8163, the Provider Reimbursement Stability Act of 2026, to reform the budget neutrality mechanism.**

III. Improving MACRA to Ensure Meaningful Quality Measurement and Reduce Reporting Burden

The passage of MACRA was necessary to remove the threat of the sustainable growth rate and combine the competing requirements of multiple measurement programs into a single program. However, over the past decade of implementation, it has become clear that the program lacks the flexibility to accommodate innovation in measurement science, technology, and modern approaches to incentivizing value-based care arrangements. Efforts to reform the program such as the move to MIPS Value Pathways have suffered from the same lack of flexibility, resulting in compromise solutions that fail to fully solve underlying problems with the system. If Congress seeks to improve Medicare physician payment, they must empower or direct the agency to break out of the constraints of the current program and rethink how we define and measure quality. Below are some suggestions based on the ACS' experience with verification and building quality programs.

Adopt Programmatic Measures

The ACS sees quality as a comprehensive program built around the patient, and inclusive of the entire team involved in providing care for patients with a given condition or diagnosis. The current model of individual,

disconnected measures is insufficient to achieve coordinated, patient-centered, high-value care and provides little actionable information for physician improvement or patient decision making when it is time to seek care. This is especially true in rural and under-resourced areas where regional shortages in surgeons and other care providers can lead to reduced access and fewer choices for care.

Most physicians in the current FFS system are evaluated on measures that do not reflect the care they deliver to patients or the conditions they treat. Further, the payment update associated with the reported data applies two years after the data has been reported. This means that no actionable, recent information is available for improvement or to help patients choose the best care for them. In contrast, the ACS has designed quality programs to overcome barriers faced by surgeons and other physicians who want to work together to coordinate and improve care. Based on these efforts and the more than 100-year history of the ACS working to improve the quality and value of care for surgical patients, the ACS believes addressing the shortcomings of traditional Medicare FFS payments will require new types of quality measures, facilitated by increased flexibility in participation and scoring options in MIPS. As described below, such a combination will improve care coordination and reduce surgical complications.

The ACS believes that we must refocus on the patient by incorporating shared decision-making and patient goal identification for goal-concordant care. To deliver on patient goals, it is critical that a verified quality program is in place, ensuring the right structures, processes, and personnel. All of this information should be transparently portrayed to help patients find and access such care. **ACS Verification programs, such as the Quality Verification Program (QVP) and the Geriatric Surgery Verification (GSV) Program, are examples of programs that align care teams around the needs of patients**. The framework used in these ACS Verification Programs is the basis of "programmatic measures," which more accurately assess the ability of a system to provide high-quality care to patients. Programmatic quality measures do the following:

- Align multiple structures, processes, and outcome measures, including patient-reported outcomes;
- Focus on shared decision-making and goal concordant care;
- Target condition or population specific care;
- Apply to multiple quality domains;
- Follow the continuum of care; and
- Create actionable quality improvement information for care teams.

Our experience with programmatic measures exhibits applicability to diverse care settings, limited burden on care providers, and demonstrably better results. Applied correctly, programmatic measures will address the quality gaps created by the current measures and ensure surgical care is measured appropriately.

Expand Scoring Options

The ACS also supports greater flexibility in how physicians and teams are measured. Under the current MIPS framework for example, we have supported expanding the existing facility-based scoring option by including more facility settings and reporting programs and applying it to all four MIPS categories (to include Promoting Interoperability and Improvement Activities, in addition to Quality and Cost as currently

in statute). Allowing for facility-based scoring and measurement in an FFS framework is in line with the ACS perspective on programmatic quality programs and is more closely aligned with how patients experience care.

A framework of shared measurement between facilities and physicians could greatly aid in care-coordination, especially when coupled with programmatic measures such as the *Age-Friendly Hospital Measure* included in the IQR program. Such a change should not appreciably increase costs because physicians would continue to be updated through the largely budget neutral MIPS program.

The ACS developed programs like GSV and QVP have demonstrated marked improvements in patient care in trauma, cancer, bariatric surgery, geriatric surgery, and other areas, all of which involve the clinical team and facilities coming together to improve the delivery of care. Alignment with facility reporting is critical for care centering the patient. **We believe a voluntary expansion of facility-based scoring to additional physicians, sites of service, and to all MIPS categories would be an important incremental step toward better coordinated value-based care. It would also greatly reduce reporting burden while creating the environment necessary for meaningful quality programs to be recognized and incentivized in the FFS payment environment.**

Engage Physician Stakeholders in APM Development

The ACS supports building a more modern care environment for patients, rewarding value and innovation. Medicine should be moving steadily toward a system that truly rewards the value of care provided rather than data entry that may have little relevance to the patients being treated, while ensuring access to high-quality care across all settings. This could partially be achieved through testing and expansion of APMs developed by and for specialists.

CMMI has recently taken important steps to expand APM opportunities for specialists such as the newly implemented Transforming Episode Accountability Model, which focuses on five categories of surgical care, and the upcoming Long-term Enhanced Accountable Care Organization (ACO) Design model, which includes CMS-Administered Risk Arrangements specifically to make it easier for ACOs to bring specialists into value-based care. These represent steps in the right direction but could be improved through greater outreach to specialty societies and physicians treating the affected patient groups. In addition, limiting innovation to CMS designed models is slowing progress. **Congress should encourage innovation by incentivizing the testing and implementation of physician-developed, value-based payment models. Models developed by subject matter experts such as specialty societies will be better structured to provide and utilize timely, actionable data and allow physicians to improve care.**

Congressional Action is Needed to Reform Medicare Payment: In Summary

Medicare physician payment reform is urgently needed. While the value-transformation is underway, it could greatly benefit from improving the foundation of the physician fee schedule as well as efficient investments in the partnership between CMS and stakeholders interested in improving the way quality is measured and incentivized. Congress has the opportunity to address recent misguided changes to physician reimbursement, as well as provide CMS with direction, flexibility, and additional authority to help achieve the goal of improving value. The ACS proposes the following specific action items for Congress to consider:

- Stop the 2.5% efficiency adjustment enacted in 2026 and future pending cuts;

- Implement an update mechanism in the MPFS to account for inflation. This will create a stable base from which physicians can make the leap to models involving risk;
- Eliminate the MPFS budget neutrality requirement or increase the trigger threshold and index it annually to account for inflation;
- Direct CMS to partner with stakeholders to test physician-developed APMs, such as those recommended previously by the PTAC; and
- Create flexibility for shared measurement and accountability in MIPS, such as through expansion of facility-based scoring.

It is critical that Congress take steps to stabilize the Medicare physician payment system, build upon MACRA's vision of value-based care, and ensure the appropriate valuation of surgical services. Federal policy should support all physicians to provide the best care for their patients in the most appropriate setting, not pit specialties against one another, or perversely incentivize consolidation. Medicare reimbursement must account for the rising cost of providing care, the increasing medical complexity of an aging population, and the essential role that physicians play in their communities.

Surgeons are committed to being part of the solution, and the ACS looks forward to continuing to work with Congress to advance these critical and necessary reforms. Thank you for convening this important hearing and for the Subcommittee's commitment to our shared goal of ensuring access to high-quality, affordable care for all Americans.

For questions or additional information, please contact Emma Zimmerman with the ACS Division of Advocacy and Health Policy at ezimmerman@facs.org.

Federation of American Hospitals

Charlene K. MacDonald
President and CEO

STATEMENT
of the
Federation of American Hospitals
to the
United States House Committee on Energy and Commerce Subcommittee on Health Hearing:
"Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms"
May 20, 2026

The Federation of American Hospitals appreciates the opportunity to submit this Statement for the Record as the Committee examines the future of Medicare physician payment policy. As the federal representative for over 1,000 taxpaying hospitals across the country, our member hospitals employ nearly 500,000 health care workers – many of whom are physicians – and care for millions of Medicare beneficiaries each year. We are deeply concerned that the current trajectory of the Medicare Physician Fee Schedule is undermining the stability of the physician workforce and, ultimately, beneficiary access to care.

Under the Medicare and Chip Reauthorization Act's (MACRA's) statutory framework, the Physician Fee Schedule is subject to a **0 percent baseline update,** meaning that payment rates do not automatically adjust for inflation. As a result, physicians have faced repeated year-over-year reductions even as the cost of delivering care continues to rise. The update included in H.R. 1 was an important temporary step to address those concerns but a sensible long-term physician payment plan is needed. The widening gap between payment rates and practice costs is not sustainable, and both MedPAC and the Medicare Trustees have warned that continued erosion of physician reimbursement may lead to access challenges for Medicare beneficiaries. For these reasons, we strongly urge Congress to establish a stable, inflation-based update to the Physician Fee Schedule to ensure that payment rates keep pace with rising input costs and support continued access to care.

More than ten years since the enactment of MACRA, Congress should evaluate whether the current framework is effectively supporting the a shift away from a volume-based system. MACRA was established to accelerate the transition to value-based care, but the experience of the past decade shows that the program has not fully delivered on that promise. Providers continue to face significant operational challenges associated with program participation, measure reporting, benchmarking methodologies and evolving technical requirements. Many of the program's core elements – such as the structure of the Quality Payment Program and the design of Advanced Alternative Payment Model (APM) incentives – have not kept pace with the evolution of care delivery. A thoughtful, bipartisan review of MACRA is needed to determine how best to modernize the framework, reduce unnecessary complexity, and ensure that incentives meaningfully support the adoption of value-based care models that improve outcomes for patients.

Finally, the **Merit-Based Incentive Payment System (MIPS)** continues to present challenges for clinicians and hospitals. The program has become increasingly complex, with reporting requirements that often emphasize process measures rather than outcomes. Persistent challenges related to measure attribution, specialty specific reporting limitations, and electronic reporting infrastructure continue to create barriers for many providers. These challenges are particularly evident in procedural and specialty care areas, where existing measures may not adequately reflect quality performance or patient complexity. We encourage Congress to work with CMS to reassess the MIPS framework, streamline reporting requirements and promote the use of clinically relevant, patient-centered quality measures that truly reflect performance and support better care.

FAH appreciates the Committee's attention to these critical issues. Strengthening the physician payment system, modernizing MACRA, and improving MIPS are essential steps toward ensuring that Medicare continues to support high-quality, accessible care for the patients and communities our hospitals serve. We stand ready to work with Congress to advance these reforms and help build a more stable and effective Medicare physician payment system.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

May 20, 2026

The Honorable Morgan Griffith
Chair
Subcommittee on Health
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
House Committee on Energy and Commerce
2323 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for holding today's critically important hearing entitled, "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms." We appreciate the committee's consideration of the current Medicare physician payment landscape and what policy changes are needed to truly modernize and stabilize the Medicare program for physicians and, most importantly, the patients we serve.

As you well know, the Medicare Access and CHIP Reauthorization Act (MACRA; P.L. 114-10) was intended to permanently resolve Medicare's flawed Sustainable Growth Rate (SGR) payment formula and help transition our health care system to one that rewards value, rather than volume. As we looked to move away from traditional fee-for-service (FFS) as the standard, MACRA was designed to establish value-based payment pathways – the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) – as well as streamline the numerous quality reporting programs under Medicare.

However, in practice the implementation of MACRA has not proven to be the fix that was promised. While the law helped address the short-term physician payment issues caused by the SGR, for the last several years the Medicare Trustees Report has reiterated that there remain "…important long-range concerns that will almost certainly need to be addressed by future legislation."[1] These concerns include specified payment updates not accounting for varying economic factors, including not keeping up with the pace of inflation and failing to rectify increasing gaps between the payment updates and growing physician costs. Given these concerns, the Trustees expect "…access to Medicare-participating physicians to become a significant issue in the long term."

We believe that with improvements developed in collaboration with Congress, regulators, and stakeholders, MACRA (or a subsequent framework) can be significantly

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[1] https://www.cms.gov/files/document/2025-medicare-trustees-report.pdf

more effective in facilitating a successful transition to value-based care delivery. It does not necessitate the wholesale dismantling of the current system as we did with the SGR, but does require more regular oversight and better integration of the varying specialties as meaningful participants in the process. This will help us develop a more viable and stable payment system that truly incentivizes high-quality, cost-effective care. To this end, ACEP responded to a recent bipartisan request for information from the House GOP Doctors Caucus and Congressional Doctors Caucus, detailing some of our proposals on legislative reforms needed to improve, modernize, and stabilize the Medicare physician payment system, and we appreciate their ongoing efforts to drive needed change.

Financial stability and certainty are critical in ensuring that Medicare can fulfill its promise to the millions of American seniors that deserve and depend upon this program. The annual issue of significant Medicare physician payment cuts not only threatens the viability of the health care safety net but also affects our ability to effectively partner with Congress to address other critical challenges facing the physician community, and most importantly, our ability to advocate on behalf of our patients. We share legislators' significant frustrations with the perennial task of finding costly, short-term fixes for long-term problems, and we support efforts to provide greater stability and certainty in the Medicare system and thank you once again for the Committee's attention to this critical issue.

Growing Financial Pressures and Unique Concerns for Emergency Medicine

Emergency physicians serve on the front line of the health care system and provide care under circumstances and laws that are unique among other physician and provider specialties. Both by oath and under the federal Emergency Medical Treatment and Labor Act (EMTALA), emergency physicians provide lifesaving emergency care to every patient regardless of their insurance status or ability to pay. As a result, we provide more uncompensated care than any other physicians or providers, and combined with growing financial and operational pressures, the health care safety net we provide is under increasing strain.

The burden of uncompensated care only continues to grow, particularly in communities with high populations of uninsured patients. A report issued by RAND in April 2025, "Strategies for Sustaining Emergency Care in the United States,"[2] brings this uncompensated care burden into sharp relief – across all payers, **20 percent of emergency physician payments go unpaid, representing $5.9 billion in annual losses**. Additionally, in order to ensure 24/7/365 access to the emergency department (ED), we work under more specialized staff and standby requirements than other types of medical providers so that we can meet the needs of patients who experience a wide range of emergencies every day, such as heart attacks, strokes, trauma, mental health conditions, and countless others.

Declining payments for emergency services further compound the financial pressure on emergency medicine. From 2018-2022, commercial insurance payments to emergency physicians dropped 10.9 percent in-network and 47.7 percent out-of-network. Medicare and Medicaid payments per visit also dropped 3.8 percent during the same period. Together, Medicare and Medicaid account for more than 65 percent of ED visits (33.6 percent and 32 percent, respectively), so the cumulative impact of continued reimbursement cuts in federal programs alone has a disproportionate effect on emergency medicine. Additionally, harmful payer reimbursement practices such as those detailed in ACEP's statement for the record for recent congressional hearings with insurance company executives, as well as growing health care consolidation, not only add financial burdens but are also major sources of stress and burnout for emergency physicians.

Necessary Structural Improvements for the Medicare Physician Payment System

ACEP strongly supports efforts to stabilize the Medicare physician payment system, including:

[2] https://www.rand.org/pubs/research_reports/RRA2937-1.html

- Establishing a permanent inflationary update based upon the Medicare Economic Index (MEI), such as the bipartisan "Strengthening Medicare for Patients and Providers Act" (H.R. 6160) led by Representatives Raul Ruiz, MD (D-CA) and Gus Bilirakis (R-FL).
- Implementing improvements and updates to the Physician Fee Schedule's (PFS) budget neutrality rules to mitigate year-to-year fluctuations in the conversion factor, such as those proposed in the "Provider Reimbursement Stability Act" (H.R. 8163) led by Representatives Greg Murphy, MD, and Jimmy Panetta (D-CA).
- Modernizing and improving the Medicare and CHIP Reauthorization Act of 2015 (MACRA) to assist in the transition toward more value-based payment models and reduce clinician burdens.

We also ask Congress to act before the end of the year to prevent any potential cut that may result from possible negative budget neutrality adjustments in the upcoming calendar year (CY) 2027 PFS rule and the expiration of temporary relief provided by Congress through the end of 2026.

Modernizing MACRA: Improving the Merit-based Incentive Payment System (MIPS)

Broadly, MACRA as implemented is a "one-size-fits-all" approach for physicians and other clinicians, regardless of specialty or practice model, thereby ignoring core differences between different modalities of care. A truly transformative, value-based payment system must recognize and be able to encompass different models of care:

- Non-episodic/scheduled care (primary care including chronic/longitudinal care management)
- Episodic/scheduled care (typically elective procedures, mostly specialty care)
- Episodic/unscheduled care (emergency care, urgent care

CMS tried to address this one-sized-fits-all constraint through the creation of the MIPS Value Pathways (MVPs). Under this optional approach, clinicians can report on a uniform set of measures on a particular episode or condition in order to get MIPS credit. ACEP developed an emergency medicine-focused MVP that CMS included in the first batch of MVPs starting in 2023. While we appreciate the implementation of our Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, we are generally concerned that based upon the reporting trends from its first performance year of 2023, there is limited uptake; likely as there are still not sufficient incentives to encourage clinicians to report through this MVP. Clinicians who report MVP data also have the option of reporting through Traditional MIPS, and CMS takes the highest score. Based on the first year of data, not only did only a small number of clinicians report through MVPs, but most who did also chose to report Traditional MIPS. These clinicians received a higher score overall in Traditional MIPS than in MVPs. For the emergency medicine MVP, 2,912 clinicians registered to report the MVP and 1,112 reported MVP data-- but only 45 clinicians received a final score from the MVP in the 2023 performance year. It is still too early to tell whether participation will increase and whether the MVP approach is a viable pathway for MIPS going forward.

There are some structural flaws within MVPs that may also be leading to low participation rates. There are no additional financial incentives for participating in an MVP – and since clinicians are generally performing better in Traditional MIPS than MVPs anyway, it may not be worthwhile for clinicians to spend additional time and effort to report to an MVP.

To help ensure MACRA's success, we ask Congress to consider refining MIPS overall, including the MVP approach established by CMS, in order to better tailor the program to the type of care a physician actually typically delivers. For example, there could be a system in which primary care continues to use traditional quality and cost measures, scheduled care could use episodes-of-care and MVP measures, and emergency care could use its own paradigm, relying on more relevant measures like the EM cost measure with a 14-day episode (as opposed to 30-day for other specialties). Such a system would better reflect the type of work a physician performs the majority of the time.

Further, the clinician community believed when MACRA was passed that the ultimate goal was for most clinicians to transition away from MIPS to participate in Advanced APMs. Besides there not being opportunities for most specialists to participate in Advanced APMs, there should also be better, and more sustainable incentives to participate in these models.

As it stands, MIPS is currently set up for larger groups to perform well and may be a more attractive and financially viable option as there is less risk, which suggests that there should be better incentives to encourage larger groups to participate in Advanced APMs. And while MIPS is burdensome, the development of quality measures requires significant effort, time, and resources, and we do not want those to simply go away. Qualified clinical data registry (QCDR) measures should still be used – they have been refined and maintained, are specialty-specific, and have been developed for the sole purpose of improving care for patients seen by such specialists.

QCDRs are third-party intermediaries that help clinicians report under MIPS, and they have proven to be an excellent way to collect data and report quality measures. ACEP developed its own QCDR, the Clinical Emergency Data Registry (CEDR), offering dozens of EM-specific measures and QPP measures spanning five domains of care. QCDR measure owners invest significant resources into measure development, data collection, and validation. Additionally, QCDR measure owners develop these measures for use beyond MIPS reporting (e.g., research, guideline development, quality improvement, etc.). Section 1848(q)(5)(B)(ii)(I) of the Social Security Act, as added by Section 101 of MACRA requires HHS to encourage the use of QCDRs to report quality measures under MIPS. In line with this statutory requirement, ACEP has urged CMS to continue refining the QCDR option under MIPS to streamline the self-nomination process and provide better incentives for organizations, including medical associations such as ours, to continue to invest in their QCDRs and develop new, meaningful measures for specialists to use for MIPS reporting and other clinical and research purposes. Conversely, CMS should refrain from finalizing proposals that would impose significant and unreasonable burdens on QCDRs, **and we strongly urge the Committee to ensure that registries like CEDR can continue to succeed and be developed further**.

Modernizing MACRA: Expanding APM Pathways & Integrating Specialty Care

To ensure APMs deliver real improvements in cost and quality while ensuring successful scaling of innovations, we urge Congress to consider a range of options to examine why specialists, including emergency physicians, have largely been precluded from participating in APMs.

As they treat each patient, emergency physicians must make a critical decision about whether the patient should be kept for observation, admitted as an inpatient to the hospital, or discharged. Essentially, they act as a gateway to the hospital for many patients. Emergency physicians are therefore in a prime position to be meaningful participants in APMs that attempt to shift our health care system to one that rewards value over volume. However, while many emergency physicians are ready to take on the downside risk and participate in Advanced APMs, there simply are not any opportunities to do so.

For context, in order to address the gap in available Advanced APMs for emergency physicians, ACEP established an internal APM Task Force to review various APM proposals, eventually resulting in the development of an emergency medicine-focused APM, the Acute Unscheduled Care Model (AUCM; affectionately pronounced "awesome"), that we have presented to regulators for incorporation into various APM initiatives. In October 2017, ACEP submitted the AUCM proposal to the PTAC. Established by MACRA, the PTAC is tasked under statute with commenting on and recommending physician-focused APM proposals to the Secretary of Health and Human Services

(HHS) for consideration, based on a set of ten criteria established by the Secretary. After months of discussions with a Preliminary Review Team (PRT) within the PTAC, ACEP officially resubmitted the model in June 2018.

In September 2018, three emergency physicians presented the model to PTAC during a public meeting. PTAC voted on the ten criteria and determined that the AUCM proposal met all ten criteria.

PTAC Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary	**Full PTAC Rating**
1. Scope (High Priority)	Meets and Deserves Priority Consideration
2. Quality and Cost (High Priority)	Meets
3. Payment Methodology (High Priority)	Meets
4. Value over Volume	Meets
5. Flexibility	Meets
6. Ability to be Evaluated	Meets
7. Integration and Care Coordination	Meets
8. Patient Choice	Meets
9. Patient Safety	Meets
10. Health Information Technology	Meets

The PTAC then voted to submit the model to the HHS Secretary for full implementation, agreeing that the model has great potential to improve the way emergency care is delivered and that it fills a huge gap in the current portfolio of APMs. One member of the PTAC even stated that it was the best APM that they had reviewed to that point. Based on the vote and recommendations made during this meeting, PTAC then formally issued a report to the HHS Secretary in October 2018 stating that AUCM deserves priority consideration based upon the scope criterion.

In September 2019, HHS Secretary Alex Azar responded[3] to the PTAC's recommendation by stating that he was, "interested in exploring how the concepts in the AUCM model for care management by emergency physicians after an ED encounter could be incorporated into models under development at the CMS Center for Medicare and Medicaid Innovation (CMMI)." But despite subsequent conversations with) CMMI has not made any tangible progress on the implementation of the model at this point.

ACEP has repeatedly raised our concerns with CMS that the agency is not doing enough to engage emergency physicians in value-based payment initiatives. For example, in our response to the CY 2026 PFS and QPP proposed rule, ACEP reiterated our call that CMS prioritize the creation of additional APM opportunities for emergency physicians and other specialists, or determine how to modify existing APMs to better engage specialists and allow them to actively participate.

At this point, with little action from CMS on the AUCM, we are working with other payers beyond Medicare to try to advance the model's core principles – including Medicaid and private payers. As these payers continue to move away from traditional fee-for-service (FFS) contracts toward value-based payment arrangements, the AUCM could be an ideal APM construct for them to adopt, at least in terms of core concepts. We anticipate that some features of these private payer APMs will be different from the AUCM depending on the specifics and needs of the targeted patient population.

ACEP encourages Congress to consider legislative options including giving more weight or authority to recommendations made by the Physician Payment Technical Advisory Committee (PTAC); mandating that CMMI

[3] https://downloads.cms.gov/files/ptac-hhssecresponse-sep18-dec18.pdf

implement new models that have been recommended for adoption by the Secretary of the Department of Health and Human Services (HHS); or, at minimum, ensuring greater transparency by requiring CMMI to report to Congress why models that have been approved or recommended for adoption have not been implemented (such a report should be retroactive to encompass all models that have already gone through this process). We also urge Congress to exercise its critical oversight role to examine why emergency physicians and other specialists have largely been precluded from participating in APMs.

Refining PFS Policy Changes to Limit Unintended Consequences

In the calendar year (CY) 2026 Medicare PFS, CMS finalized two policies that, while well-intended, do not account for the needs or realities of emergency medicine.

- **Efficiency Adjustment**: CMS finalized a 2.5 percent "efficiency adjustment" for work relative value units (RVUs) and physician intra-service time for all non-time-based codes, with additional reductions expected every three years indefinitely. This policy was based on the assumption that all non-time-based services become more efficient as those services become more common, professionals gain more experience, technology improves, and other operational improvements are implemented; however, the across-the-board methodology applied by CMS does not differentiate between services that can realize efficiencies and those that cannot, or services that have already recently undergone evaluation through existing processes. Further, advances in technology do not necessarily directly reduce the time it takes to conduct specific services and interpret results.

  Though the vast majority of emergency medicine services evaluation and management (E&M) codes are not subject to the efficiency adjustment, procedures frequently performed by emergency physicians are. These include things like ultrasounds, laceration repairs, fracture care, CPR, burn treatment, intubation, among many others. Intubation, for example, is already as efficient as possible – it is a difficult procedure that has life-or-death implications. CPR is also not an expensive or overly-inflated procedure meriting an efficiency adjustment.

  While we share CMS' goal of ensuring that PFS valuations accurately reflect changes in resource use over time, we believe this policy should at least be refined to incorporate service-specific analysis and should exempt codes that have recently been revalued. Further implementation of the policy should also be delayed to allow specialty societies to provide input on where efficiencies are achievable and where the nature of the service precludes such gains.

- **Indirect Practice Expense (PE) RVU Reallocation**: CMS also finalized a policy to reduce indirect PE RVUs in the facility setting to 50 percent of the amount used in the non-facility setting (exempting maternity care codes with an MMM global period). Indirect PE is a part of the Medicare PFS intended to account for overhead and other costs, such as rent, equipment, utilities, administrative staff, and other costs.

  In the rule, CMS acknowledged that physicians practicing in facility settings may still incur indirect PE costs, and further acknowledged that facilities may incur higher overhead costs because they must be equipped and able to furnish services 24 hours a day and 7 days per week under EMTALA. However, the rule was finalized largely as proposed and without any of the exceptions or refinements that ACEP and other organizations had requested.

  CMS believes that because fewer physicians who primarily work in facilities still own their practices, their indirect PE costs do not need to be the same as those physicians who work in non-facility settings. The intent of the policy to preserve private practice and prevent further integration and consolidation is well-meaning and is a goal that ACEP strongly supports. However, this policy also does not account for the unique practice considerations for most emergency physicians.

Most emergency physicians are not employed directly by hospitals, but instead provide services in hospitals as a group through contracts for their professional services. They operate independently and have their own set of operating expenses. CMS' Indirect PE reduction does not account for the variations in sizes, structures, and associated operating expenses of practices like these. It also disproportionately affects emergency medicine – while other clinicians and specialties may provide E/M services in non-facility settings (or a mixture of facility/non-facility), emergency physicians mainly perform evaluation and management (E/M) services that are exclusively provided in the facility setting. This reallocation treats a group's fixed costs as if the hospital has absorbed them simply because the care occurs in a facility – i.e., physician payment is reduced though the physician's costs have not changed.

Again, we share CMS' goal of preserving independent physician practice but believe this policy will have the opposite effect. Independent groups, especially smaller practices, will see shrinking reimbursement while their costs remain the same (or grow), which will exacerbate the pressures accelerating consolidation, ultimately putting ED coverage and timely access to lifesaving care at risk. We believe the intent of this policy can still be met with appropriate refinements, whether simply differentiating between those directly employed by the hospital or not (e.g., establishing a modifier to indicate employment) or at the very least excluding certain E&M and critical care services from the reduction.

We look forward to working together with Congress to identify substantive long-term reforms, and urge you to hold hearings and convene stakeholder roundtables to explore potential solutions that will guarantee the stability and security of the Medicare program, ensuring our nation's seniors have access to the high-quality care they need and deserve.

Once again, thank you for your attention to the issue of physician payment reform and for the opportunity to share our comments with you. We look forward to working together with you to develop potential solutions that will guarantee the long-term stability and security of the Medicare program, ensuring our nation's seniors have access to the high-quality care they need and deserve. Should you have any questions or need any additional information, please do not hesitate to reach out to Ryan McBride, ACEP Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

L. Anthony Cirillo, MD, FACEP
President, American College of Emergency Physicians

American Association of Orthopaedic Surgeons
Statement for the Record
U.S. House Energy and Commerce Health Subcommittee
Hearing to Examine Medicare Physician Fee Scheule and MACRA
May 20, 2026

On behalf of its 39,000 orthopaedic surgeon members, the American Association of Orthopaedic Surgeons (AAOS) is pleased to submit this statement for the record of the May 20, 2026 hearing with health care providers before the U.S. House Energy and Commerce Health Subcommittee. We share the subcommittee's goal of addressing the challenges precipitated by the enactment of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the turbulence within the Medicare Physician Fee Schedule (MPFS)—namely inadequate Medicare reimbursement, onerous government interference, administrative burdens, and lack of competition and patient choices.

As a result of an aging population, musculoskeletal diseases are an emerging cause of health and financial burden in the United States[1], affecting more than one in three people or approximately 127.4 million individuals.[2] Musculoskeletal care made up 9.4% of total medical services expenditure in 2021, translating to an annual expenditure of $244 billion. .[3] Musculoskeletal care not only makes up a significant proportion of healthcare services but also has an outsized impact on activities of daily living and productivity. The impact of MSK diseases leads to a ripple effect on not just the patient, but the caregivers, family members, and larger community involved in the therapeutic recovery from acute and chronic diseases. In fact, employers rank musculoskeletal conditions among the top two health conditions driving their costs.[4] Proactive treatment led by expertly trained orthopaedic surgeons focused on the full continuum of care management is the best way to ensure quality care that treats the patient and by extension the entire community. The doctor-patient relationship must remain at the heart of MSK care, unincumbered by payment or administrative barriers.

Impact of Physician Payment Policies

As the past ten years of MACRA have demonstrated, the transition to value-based care has been slower and more difficult than anticipated. The economics of running a modern surgical practice have contributed to these struggles. Especially for smaller, independent and rural practices, physicians would feel more comfortable taking on two-sided risk in

[1] https://pmc.ncbi.nlm.nih.gov/articles/PMC10788788/
[2] https://pmc.ncbi.nlm.nih.gov/articles/PMC10788788/
[3] https://www.kff.org/health-policy-101-health-care-costs-and-affordability/?entry=table-of-contents-what-factors-contribute-to-u-s-health-care-spending
[4] https://www.businessgrouphealth.org/resources/2024-large-employer-health-care-strategy-survey-intro

value-based care arrangements if their Medicare fee-for-service payments were fairer, more predictable and robust. Therefore, it is critically important that Congress modernize the MPFS by tying the conversion factor to inflation.

AAOS is grateful to Congress for enacting a 2.5% increase to physician payments in 2026. To ensure seniors continue to have access to the physicians they trust in their communities, Congress must act now to stabilize payments with long-term solutions. We strongly support policies that give physicians an annual, inflation-based payment update. Unlike hospitals and other facilities, physicians receive no automatic inflation-based payment updates. This disparity forces many practices to either close their doors or consolidate with larger healthcare institutions -– a trend that ultimately drives up healthcare costs for everyone. Congress should permanently modernize Medicare physician payments by requiring the annual conversion factor update to include the full amount of yearly inflation as measured by the Medicare Economic Index (MEI).

Physicians are struggling to keep up with inflation along with Medicare reimbursement cuts year-after-year due to budget neutrality constraints. The Omnibus Budget Reconciliation Act of 1989 contained a provision mandating any upward payment adjustments or the addition of new procedures that will increase spending by $20 million or more must be offset by cuts elsewhere in the MPFS. As a result, the U.S. government has pitted the various medical specialties against each other in competition over the size of their respective shares of the MPFS budget. It is not uncommon for a physician in one specialty to see their payments reduced because of policy decisions aimed at a completely different specialty. This creates even more uncertainty for physicians and ultimately harms patients.

The AAOS enthusiastically supports the *Provider Reimbursement Stability Act of 2026* (H.R. 8163) designed to stabilize Medicare payments for physicians and protect access to care for patients.

This bipartisan legislation meaningfully increases physician payments to right size reimbursements after decades of inflation-adjusted cuts. If enacted, this bill raises the budget neutrality threshold from $20 million to $54.3 million in 2027 (indexed to the MEI at five year intervals thereafter), caps the annual budget neutrality adjustment to the conversion factor at 2.5%, establishes a utilization corrections mechanism, and requires regular updates to practice expense calculations.

In addition to these ongoing challenges, certain issues arise because of policies enacted by the Centers for Medicare and Medicaid Services (CMS) and have an outsized impact on the state of physician payment. For example, CMS finalized an “efficiency adjustment” in

the CY2026 Medicare Physician Fee Schedule. This policy, which took effect January 1, 2026, applies a 2.5% cut to work Relative Value Units (RVUs) for most non-time-based codes with additional reductions scheduled every three years indefinitely absent congressional action. Because work RVUs underpin surgeon compensation across practice settings, this policy accelerates the decades-long decline in physician payment and intensifies zero-sum pressures in Medicare that can force tradeoffs across specialties and primary care. Orthopaedic surgeons, other specialists, and primary care clinicians are partners in patient care and all impacted by this adjustment.

The *Efficiency Adjustment Delay Act (H.R. 7520)* would provide a prudent pause until 2030 to reassess CMS's assumptions through a study and ensure that preserving patient access to surgical and specialty care does not come at the expense of access to front-line, preventive care. We appreciate that H.R. 7520 requires any future adjustments to work RVUs to be supported by evidence from this study. The new adjustments, if deemed necessary, would be calculated without relying on a factor that is used to determine productivity relative to inflation, such as the MEI, unless the yearly update to the nonqualifying alternative payment model (APM) conversion factor is at least as large as the percentage increase in the Consumer Price Index for the previous year.

The policy premise supporting the CMS efficiency adjustment is not supported by the evidence. A peer-reviewed study in the *Journal of the American College of Surgeons* found that 90% of procedures took the same or longer to perform in 2023 than in 2019 as patients grew more complex — contradicting the assumption that services will become more efficient indefinitely, or at the same rate across clinicians and settings.[5] Within the realm of orthopaedics, our surgeon members are at the forefront of patient optimization initiatives that succeed in improving surgical care as much as possible. Even so, the data reflects the fact that the best patient outcomes are not simply equated with the fastest operative times. Physician work valuation reflects time, complexity, and intensity, not speed alone. An across-the-board reduction untethered to empirical data fails to account for high-risk cases, surgeons newer to a procedure, and teaching environments with residents where additional time is appropriate and necessary.

The impact also extends beyond Medicare. Many employment contracts are tied to work RVUs or total RVUs, meaning cuts can reduce physician compensation even when the work

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[5] Childers, Christopher P MD, PhD; Foe, Lauren M MPH; Mujumdar, Vinita JD; Mabry, Charles D MD, FACS; Selzer, Don J MD, MS, FACS; Senkowski, Christopher K MD, FACS; Ko, Clifford Y MD, MS, MSHS, FACS, FASCRS; Tsai, Thomas C MD, MPH, FACS. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. Journal of the American College of Surgeons 241(5):p 741-744, November 2025. | DOI: 10.1097/XCS.0000000000001588

performed does not change. A recurring reduction every three years adds uncertainty that undermines sustainable practice and employment arrangements.

In addition, CMS finalized a 50 percent reduction to the indirect Practice Expense RVUs for facility-based services. This policy will have a significant negative impact on orthopaedic surgeons whose practices are largely comprised of procedures that can only be safely performed in a hospital or ambulatory surgery center, not a physician office. The impact will not be as significant on orthopaedic subspecialists who are able to perform more procedures in the office setting.

Rising costs and constant policy churn are making the MPFS increasingly unstable for physicians caring for seniors. Until both the efficiency adjustment cut is delayed and Congress develops a remedy for this severe cut to indirect Practice Expense RVUs, physicians will continue to struggle with tremendous uncertainty, harming the health of our nation. Small, independent, and rural practices will struggle most to absorb these cuts, potentially forcing them to consolidate into large systems -- an outcome AAOS, Congress and CMS all want to prevent.

The cost of providing medical services to our seniors continues to grow exponentially, yet physicians' Medicare reimbursement has decreased by 33 percent since 2001 when adjusted for inflation in practice costs. The MPFS is the only Medicare payment system not tied to inflation, an unsustainable reality as the Medicare population grows faster than ever. These financial pressures are contributing to physician burnout and forcing more independent practices and physician offices to be acquired by larger hospitals and healthcare systems. This accelerating consolidation reduces competition and threatens patient access to high-quality care, particularly in rural areas and low-income and historically marginalized communities.

Legislative Reform to Scale Innovation

AAOS members have been at the forefront of alternative payment model (APM) adoption since MACRA became law in 2015. In the ensuing decade, our members have been subjected to numerous iterations of quality and cost measures, mandatory and voluntary APMs such as the Comprehensive Care for Joint Replacement (CJR) and Bundled Payments for Care Improvement Advanced (BPCI-A) models, the newly launched mandatory surgical Transforming Episode Accountability Model (TEAM), and most recently to a newly proposed nationwide mandatory CJR-X model for lower extremity joint replacement. Throughout the introduction and implementation of these measures, AAOS and its orthopaedic surgeon members have been steadfast partners in testing innovations

to improve patient care and generate savings. Yet, the reward for embracing successful innovation and efficiency is often decreased reimbursement and increased administrative burden. Looking ahead, we urge Congress to exercise its authority to recalibrate value-based care so that it is patient-centered, physician-led, and fiscally sustainable.

Given Congress' oversight of CMS and the Center for Medicare and Medicaid Innovation (CMMI), we ask that Congress urge CMS to establish an Advanced APM that recognizes the critical role of specialty physicians in treating and managing chronic conditions. There must be a financially viable option for surgeons to lead care within the increasingly popular Accountable Care Organization (ACO) system, particularly considering the growing proportion of Medicare dollars spent on specialty care and the prevalence of chronic conditions that are treated by specialists, such as osteoarthritis and osteoporosis. The financial risk and potential rewards of providing high value specialty care must be shared downstream from the ACO with physician-led specialist teams to incentivize high value behavior. In the absence of this, if the entire bundle of risk and potential reward is siloed with the ACOs and primary care providers as it currently stands, then the only "lever" to reducing the cost of musculoskeletal health care is to avoid referring patients to specialists, potentially leading to inappropriate rationing, lost patient function or independence, high levels of dissatisfaction, and in some cases, overutilization of low-value care such as unnecessary advanced imaging.

Congress has the authority to reshape and refine the way that value-based care models are structured to ensure the most appropriate physician experts lead high-quality and patient-centered models. Specifically, the AAOS encourages CMS to develop incentives for interested participants to engage in a model that rewards innovation and high-value patient care by allowing specialists to manage care for an entire condition. For example, a specialist could manage care for knee pain, not just the eventual total knee replacement surgical episode. This voluntary, nationwide model should be available for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to generate high quality care, improved care coordination, and lower costs for musculoskeletal care.

It is essential that interested parties have the physical and financial infrastructure necessary to carry out an episode of care approach to payment and delivery. A key component of this is ensuring that any payment structure used is one that accounts for inflation and other changes having a direct impact on the financial viability of physician practices. Additionally, physicians must know the benchmark or threshold they are required to meet at the start of the performance year, and CMS cannot move the threshold each year to generate more savings. Physicians deserve to be rewarded for delivering savings, not punished for succeeding by facing further cuts each year.

AAOS appreciates that CMMI is interested in developing specialist-led models that incentivize better upstream care for patients with chronic conditions. However, AAOS believes the design of the Ambulatory Specialty Model (ASM) as it will apply to orthopaedic surgeons treating low back pain is deeply flawed and will not achieve the stated goals of the model. Therefore, AAOS does not support the model as designed. There is a myriad of issues, ranging from problems with the attribution and scoring methodologies to an inability to meaningfully impact care systems. While we wholeheartedly agree with the strategy of creating specialist-led models for impactful change in musculoskeletal care across the population, starting with this model will be both unsuccessful in achieving CMS' goals and will likely sour future attempts to push these important goals forward. **Accordingly**, **we respectfully request that Congress ask CMS to withdraw the ASM from consideration in its current form and work with AAOS to improve the model's design**.

The Role of Payment Reform in Value-Based Care

As it pertains to orthopaedic surgery, a shift to value-based models under MACRA is complicated and costly with limited return on the investment. Physicians are too overloaded with administrative burden to comply with the numerous value-based payment models and patients are often unaware that they are participating in such arrangements, thus limiting the effectiveness of such programs. While each of these models and programs have attempted to improve quality and contain costs within the Medicare program, evidence suggests that their success has been limited at best. A 2023 report from the Congressional Budget Office (CBO) analyzing the CMS' CMMI activities in the first ten years of its operation determined that they increased direct spending by $5.4 billion. Furthermore, CMMI spent $7.9 billion on model operation, yet those models (including CJR and BPCI-A) only reduced spending on health care benefits by $2.6 billion.[6]

Essential to any reform of value-based care is the assurance that implementation of new models will provide financial stability to physicians while encouraging competition, collaboration, and patient choice. Participation in APMs often requires significant investments in infrastructure and data analytics to succeed. As a result, many independent practices, particularly small or rural, may be forced to choose between integrating into a larger system to access the necessary capital and resources, or remaining independent but unable to participate in value-based care at the scale required to see a return on the

[6] https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf

investment. **We ask that Congress provide CMS with financial resources specifically dedicated to incentivizing participation in value-based care by smaller independent private practices and rural practices**. Possible solutions include: offering funding for technical infrastructure upgrades, an upside-only track in the early years of a model, lower savings requirements, higher bonus payments, or many other options to help practices adjust to the financing of value-based care.

AAOS recommends financial stability and predictability to be a key pillar of all MACRA reform. Payment models should invest in and recognize the significant impact of physicians' contributions to delivering high quality, high value care, and the savings to Medicare that this produces. By working upstream to treat chronic conditions and prevent hospitalizations, physicians and their provider teams are delivering value that has a domino effect on the entire economy. Rewarding this through consistent upward trends in reimbursement that are tied to these quality outcomes is the most pragmatic approach to reshaping the Medicare payment and quality system.

Specialty Care Reform

AAOS also supports the creation of voluntary, physician-led APMs that expand access to quality specialty care through a wider approach to musculoskeletal disorders. This includes care teams that assess the clinical and social factors that make surgical and nonsurgical interventions safe, effective, and long-lasting. Orthopaedic surgeons should remain the foremost leaders of these care teams which may include mid-level practitioners, nurse navigators, physical therapists, social workers, and dietitians.

Reduced administrative burden is essential to improved access. Any regulation that detracts from time spent with the patient slows the treatment process.

We recommend new models should begin with no risk and allow progression to risk-bearing as experience is accumulated. Special emphasis should be given to rural locales where large geographic areas must be covered to gain the efficiency required for the practice economics of VBC. This will require more effective use of telemedicine from physician to -physician, and not just from physician to patient. Risk bearing is challenging in a sparsely populated area as there is no option to distribute care elsewhere.

AAOS has developed and previously discussed a specialty-care focused model that is intended to incentivize the uptake of surgeon-led, condition-based bundled payments for comprehensive musculoskeletal care with CMMI. The model proposes a mechanism for interaction between primary care providers and musculoskeletal multi-specialist teams that will help support more comprehensive musculoskeletal care earlier in patients' disease or condition progression by including bundle triggers that occur prior to the need

for surgical interventions. AAOS believes the proposal aligns with CMMI's principles of improving outcomes, decreasing costs, and empowering patients and physicians to collaborate for better health.

This model envisions a healthcare system that is proactive, patient-centered, and driven by evidence-based best practices. It emphasizes prevention, effective care through delivery of high-value services, and aligning incentives to optimize outcomes and control costs. Unlike ASM, AAOS' proposal will engage all necessary medical professionals to manage chronic musculoskeletal conditions and evaluate them using quality and cost metrics that reflect their expertise and effectiveness in providing this care. AAOS stands ready and willing to discuss this type of model with Congress and CMMI, including options for modifying existing and proposed ACO models.

AAOS appreciates that, as part of MACRA, Congress created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to receive, review, and recommend these types of stakeholder-submitted models to CMS. Unfortunately, PTAC has not had the impact Congress intended, and CMS has not implemented in full any model recommended by the Committee. Physicians provide critical perspectives and ideas on how to best deliver value-based care built on their experiences serving patients in their communities every day. AAOS asks that any MACRA modernization legislation includes improvements aimed at empowering the PTAC, or a new mechanism through which physician stakeholders can submit models for consideration. Allowing practicing physicians to shape value-based care will improve the experience for the physicians, their patients, and the Medicare program.

Merit-based Incentive Payment System (MIPS) Reform to Reduce Administrative Burden

AAOS supports the ***Medicare Physician Data-driven Performance Payment System Act of 2026*** (H.R. 8622). This bill takes important steps to address the challenges and shortcomings of the current MIPS program, and the AAOS is particularly pleased with several provisions that will improve the frequency and quality of performance feedback given to physicians, create a sustainable model for participation, and offer greater transparency for cost attribution to enable efficient resource use. The legislative text successfully tackles the key issues with the current MIPS program by appropriately balancing the incentive structure with the need for financial stability, mitigating the disproportionate distribution of steep penalties, ensuring CMS provides timely and actionable data, and incorporating clinically relevant and less burdensome metrics.

Instead of continuing to promote burdensome, complicated models which are subject to changes in methodology year-over-year, Congress should direct CMS and CMMI to explore options for providing care in a way that is of high value while remaining accessible in implementation. This may look like a single system for designing and operating all payment models, with one platform for measure testing, approval, and use, and reporting. Such a platform would ideally be compatible with both government-operated and privately operated value-based care programs.

AAOS views the inclusion of Patient-Reported Outcomes-Performance Measures (PRO-PMs) as a foundational metric for physician-led APMs. PRO-PMs are crucial to improving quality and ensuring high-value patient outcomes. AAOS appreciates that CMMI included the Hospital-Level Total Hip and/or Knee Patient-Reported Outcome-Based Performance Measure in the Lower Extremity Joint Replacement Episode of the TEAM APM. Furthermore, AAOS commends CMS for increasingly using PRO-PMs to bring the patient voice into care and better distinguish the care being provided by individual orthopaedic surgeons. The MIPS orthopaedic specialty measures set includes several PRO-PM options. AAOS believes these measures, while imperfect, are a step in the right direction toward better measuring orthopaedic surgeons on the care they provide and outcomes they produce to improve patients' health. Moving forward, the AAOS asks that Congress create incentives to encourage physician-led PRO-PM development and measure testing timelines. Likewise, AAOS has previously asked that CMS continue to work with orthopaedic surgeons to ensure measures relevant to us and our patients are available for use with maximum scoring potential. Better measures, combined with a more streamlined reporting structure, will help reduce physician burden and leave more time for us to care for our patients.

Leveraging Data to Advance Quality

Currently, physicians are disincentivized to report through a Qualified Clinical Data Registry (QCDR) or devote resources to measure development when there is no stability in quality reporting policies. The policies of the current Merit-based Incentive Payment System (MIPS) fail to acknowledge the time needed to put new guidelines and standards of care into practice. In addition, it takes time for sufficient data to be collected for benchmarking and tracking progress over time, incurring additional implementation costs for physicians.

On a broader level, Medicare claims data is integral to AAOS' registries' ability to leverage data to help our members improve the value of care they deliver to their patients. QCDRs help with improving population health outcomes, effectiveness of care pathways, and surveillance of drugs and devices. To create a sustainable future for the

Medicare program, policymakers must focus on ease of access and interoperability of Medicare data to aid in decisionmaking and quality improvement.

Specifically, AAOS uses this data to analyze and regularly publish device-level survivorship data, thus ensuring that orthopaedic implants are performing as expected. It is important to incentivize the creation and ease of managing of QCDRs as the U.S. population ages and the health care sector moves to more value-based investments. The inability for AAOS to access Medicare claims data easily, regularly, and cost-effectively as a QCDR has been a significant obstacle for the research and quality improvement capacities of our registries. MACRA included a provision, Section 105(b) "Expanding the Availability of Medicare Data", which was supposed to have taken effect on July 1, 2016 and would have granted QCDRs access to Medicare claims data for quality improvement and studies of patient safety. It is our understanding that CMS chose to instead use an existing process to comply with Section 105(b) due to a lack of new funds for this requirement.

CMS later announced they would not adopt the directive from Congress to grant QCDRs access to Medicare claims data and asked that registries apply to become "Quasi Qualified Entities" to obtain Medicare claims data, a lengthy process which does not satisfy the requirement of MACRA.

As it currently stands, CMS directs registries to access its program data through the Virtual Research Data Center (VRDC), a virtual research environment under which QCDRs can technically access Medicare claims data. However, the VRDC is limited to narrowly defined research questions and is slow, costly to access, and cumbersome for registries to work with. Clinician-led clinical data registries require long-term and continuous access to large Medicare data sets to better track clinical outcomes over time. The inability of CMS to effectively implement Section 105(b) of MACRA impedes clinician-led clinical data registries from conducting longitudinal and other data analyses essential for enhancing quality, ensuring patient safety, and optimizing cost-effectiveness. An updated process that provides continuous, long-term access to data at a reasonable cost is necessary to improve this critical aspect of patient care.

The AAOS asks that Congress consider the Access to Claims Data Act (H.R. 4331) and direct the Secretary of the Department of Health to establish a process to expand access to claims data under certain Federal health programs to facilitate research and quality improvement. The legislation would require CMS to establish a program to broaden the allowable uses for which clinician-led data registries can access claims data and make the data available in a timely manner for a fee equal to what it costs CMS to provide the data. This will allow registries to conduct better patient-centered research and provide greater value to CMS's many facility and physician-level quality improvement programs.

Conclusion

The American Association of Orthopaedic Surgeons urges Congress to take immediate action to address the growing challenges facing physicians and their patients in the U.S. healthcare system. By increasing and stabilizing payments through the Medicare Physician Fee Schedule, providing better opportunities for specialist physicians to lead patient-centered value-based care models, and leveraging QCDR data to advance quality, Congress can help to reverse the trend of consolidation, preserve patient access to care, and accelerate the transition to value-based care. The AAOS stands ready to work with the Subcommittee and other stakeholders to advance these critical priorities and ensure that our nation's healthcare system remains robust, innovative, and patient-centered for years to come. Thank you for the opportunity to submit this statement for the record, and we look forward to continuing to engage with the Subcommittee on these critical issues.

May 20, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2123 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S House of Representatives
2123 Rayburn House Office Building
Washington, DC 20515

Re: Statement for the Record for the House Committee on Energy and Commerce Subcommittee on Health Hearing, "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reform"

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) thanks you for holding this important hearing on "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reform." Congress must intervene to create long-term stabilization for the Medicare reimbursement system that has long threatened the livelihood of our nation's medical practices.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following legislative recommendations.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was enacted to repeal the flawed Sustainable Growth Rate (SGR) formula, stabilize payment rates to physicians in Medicare fee-for-service (FFS), and incentivize physicians' transition to value-based care models through the Quality Payment Program (QPP). While well-intentioned, MACRA's methodology for updating the Medicare Physician Fee Schedule (PFS) does not keep pace with rising practice costs and inflation and often simultaneously cuts reimbursement for physicians.

Comprehensive reform is needed to address the multi-faceted issues undermining Medicare payment and the QPP. We offer the following recommendations for legislative action that would address these concerns and allow physician practices to focus on providing high-quality, cost-effective care to their communities.

Medicare Part B Payment Reform

Medical groups continue to feel the negative consequences that the inadequate Medicare payment system has on practice operations as it exacerbates costly administrative tasks and undermines the viability of medical groups. MGMA members have illuminated for years the fallout from these policies ─ financial

precarity, increased staffing challenges and burnout, access challenges for Medicare beneficiaries, and increased consolidation.[1] In addition to failing to cover the cost of providing care to Medicare beneficiaries, given the centrality of Medicare rates to benchmarks for commercial payers and Medicaid, inadequate Medicare reimbursement has cascading effects across payers.

Physician practices dealt with a 2.83% cut to the Medicare conversion factor for all of 2025 that compounded other financial pressures such as staffing shortages and rising operating costs. While we appreciate Congress for passing a 2.5% increase to 2026 Medicare reimbursement, 2026 payment rates are barely above 2024 reimbursement levels. This minor increase is undercut by other policies finalized by the Centers for Medicare & Medicaid Services (CMS) that decreased reimbursement for certain specialties. Given the downward trajectory of Medicare reimbursement, with its frequent reductions and lack of an inflationary update, it is time to enact structural reform to stop the significant negative impact of inadequate reimbursement.

The Strengthening Medicare for Patients and Providers Act (H.R. 6160) would make structural changes to the Medicare payment system that are needed to support medical groups and avoid annual threats to their financial viability. This legislation would provide an annual Medicare physician payment update tied to inflation, as measured by the Medicare Economic Index (MEI). An inflationary update is necessary to not only align with other CMS payment systems, but also to adequately account for the cost of operating a medical group.

Further, the Medicare PFS has been subject to antiquated budget neutrality requirements that trigger broad cuts to Medicare reimbursement to offset changes in Relative Value Units (RVUs) that exceed a low threshold. These rules have destabilized Medicare payment over the years and undermined the ability of medical groups to continue treating Medicare beneficiaries. The Provider Reimbursement Stability Act (H.R. 8163) would make modernizing changes such as increasing the budget neutrality threshold from $20 million to $54.3 million and indexing it to inflation. It would also allow for the correction of erroneous utilization estimates of Medicare services to avoid unwarranted cuts. MGMA looks forward to working with Congress to pass these two critical bills in unison to stabilize Medicare payment.

Quality Payment Program Reform

The Merit-based Incentive Payment System (MIPS)

MACRA replaced the sustainable growth rate formula with the QPP that includes two reporting pathways to facilitate the transition to value-based care: MIPS and Advanced Alternative Payment Models (APMs). MIPS has been plagued with issues as complying with the program is a time-consuming and laborious process. Studies have shown the significant amount of staff time and money dedicated to MIPS reporting with an average cost of $12,811 per physician, and clinicians and administrators spent more than 200 hours per physician on MIPS reporting activities.[2] Medical groups report that the significant program compliance costs associated with MIPS take valuable time and resources away from clinical priorities. The reporting burden is substantial — 86 percent of MGMA members surveyed who participate in MIPS

[1] *See* Testimony of incoming MGMA Board Chair Jeffrey Smith to the U.S Senate Special Committee on Aging, Feb. 11, 2026, https://www.mgma.com/advocacy-letters/february-11-2026-mgma-testifies-on-regulatory-burden-and-physician-burnout.

[2] Dhruv Kullar, MD, MPP; Amelia M. Bond, PhD; Eloise May O'Donnell, MPH, "Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System," JAMA Network, May 14, 2021, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947.

found reporting to lead to increased administrative burden with little clinical benefit.[3] "MIPS is especially unworkable," as one MGMA member succinctly put it in our 2026 survey. This aligns with what MGMA members have unfortunately said for years.

MIPS reporting requires clinicians to report on quality measures that are not clinically relevant to their practice. Medical groups often do not know what cost measures they are being scored on, and which patients have been attributed to them. CMS does not provide timely and actionable feedback to allow clinicians to understand and improve their performance. Exacerbating these reporting concerns are the steep payment cuts that medical groups face often due to opaque scoring methodologies and the punitive tournament-style model.

To address these significant concerns, we recommend Congress reform the MIPS program to improve its clinical relevance and reduce the cost and administrative burden of reporting. Specifically, Congress should pass the Medicare Physician Data-driven Performance Payment System Act (H.R. 8622). This bill would eliminate MIPS' tournament-style scoring approach that leads to penalties and tie payment adjustments to annual payment updates. It would freeze the current performance threshold to promote stability in the program. Lastly, the bill would ensure CMS provides timely feedback reports and claims data during the performance year. These changes would help mitigate many of the current issues plaguing MIPS.

APMs

The APM incentive payment has been essential to medical groups attempting to transition to value-based care models, allowing them to make the necessary infrastructure investments to succeed in these arrangements. The lapse of the incentive payment in 2025 contributed to increased financial instability for practices and prevented them from making critical investments in value-based care operations and technologies. We thank Congress for passing the Continuing Appropriations Act, 2026, that reinstated the Advanced APM incentive payment at 3.1 percent for the 2026 performance year and reverted the 2026 qualifying APM participant (QP) thresholds at the 2024 level. Congress should work to further extend these policies to ensure that APMs offer a viable and stable pathway for medical groups to transition to value-based care.

MACRA also established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) as an avenue for experts in physician-focused payment models to review and recommend models endorsed by physician stakeholders. MGMA continues to believe the models that will best align with CMMI's original charter to improve coordination, quality, and efficiency of health care services are those that come from providers. CMMI has yet to adopt any models recommended by PTAC. In the past year, CMMI has branched into new types of models that cater towards technology companies as the primary participants. The Wasteful and Inappropriate Service Reduction (WISeR) and Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) models both target technology companies, not physicians, as participants, shifting the focus of improving care away from those who are responsible for providing care. While the integration of innovative technologies is a critical component of health care, real improvements in cost and quality will come from models that focus directly on how physicians provide care. A recommitment between CMMI and PTAC to establish a pipeline of physician-focused models that are seriously considered by CMMI is necessary to ensure the future of successful value-based care opportunities.

[3] MGMA's 2026 Regulatory Burden Report, Apr. 9, 2026, https://www.mgma.com/federal-policy-resources/april-9-2026-regulatory-burden-report.

As part of a renewed focus on physician-focused models, CMMI should also commit to keeping models voluntary. Voluntary models allow providers who have the necessary resources and support to fully invest in a successful transition to value-based care. When new, untested models are made mandatory, it can create unnecessary financial and administrative burdens for practices who are not in a position to participate in a given model. Forcing providers to participate in models before they're prepared to do so, and without sufficient financial support, will not result in successful transitions to value-based care.

Conclusion

MGMA sincerely appreciates your attention to reforming MACRA and the Medicare PFS. We urge you to pass the above-referenced legislation to address years of inadequate Medicare reimbursement and administrative burden, and reinforce group practices' ability to provide high-quality, cost-effective care. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

ACS Statement on the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms

Quality has been the cornerstone of the American College of Surgeons (ACS) since its founding more than 110 years ago. But optimal quality, the centerpiece of the ACS' mission, is not achievable without optimal access. Recent regulatory changes to the Medicare physician fee schedule (MPFS) have systematically devalued surgical care, threatening patient access to critical services. In addition, long-term structural challenges persist within the payment system and with implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). These challenges include:

- **Regulatory Devaluation of Surgery:** Physicians were faced with a 2.5% cut to work Relative Value Units (RVUs) and intra-service time for all non-time-based codes in 2026, in addition to reductions in facility-based practice expense RVUs earned for procedures performed outside an office setting. These changes disproportionally affect surgical and other procedural specialties, put further strain on the surgical workforce, and threaten patient access to care.
- **Structural Limitations of the Physician Fee Schedule:** The MPFS remains the only Medicare payment system that is not indexed for inflation, and physicians have seen their reimbursement decline over the last several years while practice expenses such as rent, equipment, staffing, and utilities have increased. This challenge is compounded by overly strict budget neutrality requirements, which trigger across-the-board cuts when fee schedule changes increase spending by as little as $20 million annually.
- **Insufficient Quality Measures:** Most physicians in Medicare fee-for-service (FFS) are still evaluated based on measures that do not assess care delivered to their patients or the conditions they treat, meaning no information is available for improvement efforts or for patients and referring physicians to make care choices.
- **Lack of Alternative Payment Models:** Many surgeons wishing to move beyond FFS will find few physician-focused alternative payment models (APMs) are available for them. Current options are largely mandatory and some limit the ability of interested parties to opt-in. This is compounded by the failure to test voluntary, physician-directed models approved by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Congress can address recent misguided changes to physician reimbursement, as well as provide the Centers for Medicare & Medicaid Services (CMS) with direction, flexibility, and additional authority to help achieve the goal of improving value. The ACS proposes the following specific action items for Congress to consider:

- **Stop the 2.5% efficiency adjustment enacted in 2026 by passing the *Efficiency Adjustment Delay Act (H.R. 7520)* and address future pending cuts.**
- **Implement an update mechanism in the MPFS to account for inflation. This will create a stable base from which physicians can make the leap to value-based APMs.**
- **Eliminate the MPFS budget neutrality requirement or increase the trigger threshold and index it annually to account for inflation.**
- **Direct CMS to partner with stakeholders to test physician-developed APMs, such as those recommended previously by the PTAC.**
- **Create flexibility for shared measurement and accountability in the Merit-based Incentive Payment System, such as through expansion of facility-based scoring.**

ConnectedHealthInitiative

May 20, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
Washington, District of Columbia 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
Washington, District of Columbia 20515

RE: Health Subcommittee Hearing on *Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms.*

Dear Chairman Griffith and Ranking Member DeGette:

Thank you for holding this hearing on the Medicare Physician Fee Schedule (PFS), the Medicare Access and CHIP Reauthorization Act (MACRA), and other opportunities for payment reforms. It is imperative that the Subcommittee continue its work improving health outcomes and reducing costs for all Americans, but especially for Medicare and Medicaid beneficiaries. The Connected Health Initiative (CHI) is glad to submit a statement for the record on this important topic.

CHI is the leading multistakeholder policy and legal advocacy effort dedicated to connected health technologies that improve health outcomes and reduce costs. We seek to advance responsible pro-digital health policies and laws in areas including reimbursement/payment, privacy/security, effectiveness/quality assurance, U.S. Food and Drug Administration (FDA) regulation of digital health, health data interoperability, and the rising role of artificial/augmented intelligence (AI) in care delivery. As you examine ways to implement payment reforms in Medicare, we urge you to consider the following opportunities for improvement.

Wearable Health Technologies and Artificial Intelligence

Data and clinical evidence from a variety of use cases continue to demonstrate how digital health technologies available today can improve patient care, prevent hospitalizations, reduce complications, and improve patient engagement. These benefits are particularly impactful for the chronically ill. Connected health tools, including wireless health products, mobile medical devices, software as a medical device, mobile medical apps, and cloud-based portals and dashboards, can fundamentally improve and transform American healthcare. Despite the proven benefits of connected health technology to the American healthcare system, statutory restrictions

and regulatory-level policy decisions at the Centers for Medicare & Medicaid Services (CMS), among other constraints, inhibit the use of these solutions.

Thanks to CMS' expanded support in the last few years, reliance on digital health technologies has increased over the last decade. Use of these tools continues to allow many underserved populations to access prevention, diagnosis, and treatment for both acute and chronic conditions. CMS should leverage every opportunity for permanent policy changes that will incent responsible deployment and use of innovative digital health technologies that will be vital in ensuring that no American beneficiary is left behind. We urge you to direct CMS to take stronger steps toward inclusion of digital health tools, especially wearable health technologies and artificial intelligence.

Treatment of artificial intelligence (AI) health tools must also be modernized. CHI recognizes that many AI health tools pose some risk to patients and providers, but not all risks are uniform, and they should be accounted for differently depending on the level of threat. A clear risk-based approach to AI health would differentiate between scheduling software, educational chatbots, and software that supports clinical decision-making. CHI has frequently advocated for such an approach, including in our recent letter to CMS on their PFS rulemaking process.[1]

Further, to ensure responsible and transparent use of AI health tools across the health system, we urge you to direct CMS to align with consensus medical AI terminology[2] and CHI's cross-sectoral consensus understanding of the unique roles and interdependencies/shared responsibilities amongst the healthcare AI value chain[3] as a baseline for CMS' approach to health AI. Responsibility must be shared between model developers, large licensees, and end users, among others to ensure that the use of AI in healthcare is clear, risk-aware, and transparent for patients and healthcare providers.

Remote Physiologic and Remote Therapeutic Monitoring

CMS' continued support for remote monitoring capabilities, both remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM), continues to represent a significant and positive shift of the Medicare system to recognize the value of the wide range of asynchronous technologies, which will contribute to a more connected continuum of care while improving outcomes and reducing Medicare costs. CHI continues to find enthusiasm throughout the healthcare continuum for CMS's leadership in providing support for these critical services. Since its activation and payment, utilization is strong with providers and patients seeing increasing

[1] https://connectedhi.com/connected-health-initiatives-recommendations-for-the-center-for-medicare-and-medicaid-services-future-calendar-year-2027-medicare-physician-fee-schedule-and-quality-payment-program-rulemaking/
[2] E.g., https://www.ama-assn.org/practice-management/cpt/cpt-appendix-s-ai-taxonomy-medical-services-procedures.
[3] https://connectedhi.com/wp-content/uploads/2024/02/CHI-Health-AI-Roles.pdf.

value in the use of remote monitoring. CHI further appreciates continued efforts by CMS to provide guidance on both RPM and RTM Current Procedural Terminology ® (CPT) codes, which, over the last few years, have provided key clarifications for all stakeholders (e.g., that RPM services may be used for both chronic and acute conditions, among many others).

CMS should permanently permit RPM services to be furnished to both new and established patients, and for consent to be obtained verbally. During the COVID-19 Public Health Emergency (PHE), CMS clarified that RPM services may be applied for patients with acute and chronic conditions on a permanent basis. However, restrictions on the use of RPM and RTM still apply for many patients. For example, under current CMS policy, only one provider, in a 30-day billing period, may bill RPM for a given patient. Doing so undercuts the ability for multiple specialists to remotely monitor a single patient, even when monitoring and treating separate episodes of care. This discourages the use of RPM and RTM in chronic or complex cases, which are also the cases for which remote monitoring can be most effective.

Further, CMS should continue to clarify the shared or divergent policy nuances between RTM and RPM services such as whether RTM is allowed for patients with acute and chronic conditions, if RTM requires an established provider patient relationship, and how consent may be obtained. We urge the Committee to conduct oversight on the progress of RPM and RTM code development, including payment and key restrictions.

Practice Expenses for Software Tools

Over recent years, CMS has issued multiple requests for comments and information on technology and digital medicine topics, which parallel the topics addressed in this year's Software as a Service (SaaS) Request for Information. Despite CMS's repeated inquiries about software-based technologies and AI, and concerns about outdated methodologies for supporting clinical decision-making in outpatient and physician office settings, the agency has yet to provide substantive public clarity. We ask you to direct CMS to modernize its policies by explicitly incorporating Software as a Medical Device (SaMD) into the current payment methodology as a direct practice expense (PE) relative value unit (RVU).

While CMS has traditionally considered SaMD to be an indirect cost (effectively, a refusal to reimburse any costs for SaMD), beginning in 2022, CMS has consistently indicated its interest in revising its approach to SaMD. Until that systemic change is accomplished, CMS has been cross-walking payment rates for SaMD-inclusive codes to different services' whole rates that are similar to what CMS would have paid if the SaMD product had been included as a direct input. CHI appreciates these interim steps taken by CMS but recognizes that cross-walking is not a long-term solution. Given the rise of digital health solutions, CMS now has an ethical obligation to steward Medicare beneficiary access to leading clinically-validated SaMD treatment solutions.

CMS should seize this opportunity to advance meaningful PE methodology reform, taking a leadership role in advancing modernized coverage and payment policies across the U.S. healthcare ecosystem.

In particular, SaMD must be classified as a direct practice expense under medical equipment, not as "computer software" that falls under indirect and non-allocable practice expenses. CMS has acknowledged that its current PE methodology struggles to account adequately for innovative technologies like software algorithms and AI, as noted in prior rules from 2021 and 2026. PE consists of direct costs (clinical labor, medical supplies, medical equipment) and indirect costs (administrative labor, office expenses, and other costs including computer software); direct costs are estimated per service, while indirect costs are mostly non-allocable and based on outdated data from the Physician Practice Information Survey last conducted in 2007-2008, before many current digital health technologies existed. Software supporting clinical decision-making is simply considered "other expenses" like administrative labor. Since SaMD qualifies as a medical device, the regulatory and financial responsibilities for SaMD manufacturers are as stringent as those for hardware device makers. Therefore, categorizing SaMD as an indirect expense is inappropriate; it should be recognized and reimbursed as a direct practice expense aligned with medical equipment, whether physical or software-based.

Realizing Congress' MACRA Goals

CHI strongly supports the expanded use of digital health innovations to advance value-based care, which is necessary to accomplish Congress' goals established in the Medicare Access and CHIP Reauthorization Act.

CHI has urged CMS to facilitate and reward the flexible, broad adoption of tools ranging from remote monitoring to AI across the Merit-based Incentive Payment System (MIPS). To reduce provider confusion and burnout, Congress should enable CMS to eliminate overly burdensome Promoting Interoperability (PI) compliance and reporting requirements that deliver little benefit to patient care, while also moving away from rigid, technology-specific mandates that hinder clinicians' ability to adopt and scale the most effective digital health solutions for their beneficiaries.

CHI also supports a robust Alternative Payment Model (APM) ecosystem and emphasizes that digital health innovations are essential to its success. By enabling seamless data sharing with participating physicians and supporting an optimal mix of in-person, virtual, and remote monitoring services powered by medical wearables and AI, these technologies help create a truly connected continuum of care. CHI therefore encourages CMS, with Congress' support and oversight, to seize every opportunity within the Quality Payment Program (QPP) to transition away from legacy measurement approaches and fully realize value-based care.

CHI emphasizes that a successful Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model is vital to accomplishing Congress' MACRA goals because it represents a concrete, scalable advancement of the value-based care framework that MACRA established in 2015. By creating Outcome-Aligned Payments (OAPs) for technology-supported chronic care management, the ACCESS Model should, with Congress' support, directly advance MACRA's core objective of shifting Medicare away from volume-driven fee-for-service payments toward accountability for quality, outcomes, and cost efficiency. Congress should also ensure that the ACCESS Model strengthens the APM pathway under the QPP by demonstrating how digital health tools, such as remote monitoring, wearables, AI, and virtual care, can deliver a flexible, connected continuum of care that improves beneficiary health while reducing reliance on burdensome, activity-based reporting. If successful, ACCESS will provide critical evidence and momentum for broader APM adoption, ease the transition out of legacy MIPS programs, lower provider burnout, and help realize MACRA's vision of a truly patient-centered, outcomes-driven Medicare system.

Conclusion

This hearing comes at a key time for CMS as the annual PFS process begins again. While the agency has made positive steps in recent years, it is past time for them to truly modernize the way software and innovative tools are treated by the Medicare payment system. We urge you to conduct oversight on this topic, and to direct CMS to increase their modernization efforts around software, remote monitoring, and AI issues.

Sincerely,

Brian Scarpelli
Executive Director
Connected Health Initiative

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

May 20, 2026

The Honorable Morgan Griffith
Chair
Subcommittee on Health
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
House Committee on Energy and Commerce
2323 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for holding today's critically important hearing entitled, "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms." We appreciate the committee's consideration of the current Medicare physician payment landscape and what policy changes are needed to truly modernize and stabilize the Medicare program for physicians and, most importantly, the patients we serve.

As you well know, the Medicare Access and CHIP Reauthorization Act (MACRA; P.L. 114-10) was intended to permanently resolve Medicare's flawed Sustainable Growth Rate (SGR) payment formula and help transition our health care system to one that rewards value, rather than volume. As we looked to move away from traditional fee-for-service (FFS) as the standard, MACRA was designed to establish value-based payment pathways – the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) – as well as streamline the numerous quality reporting programs under Medicare.

However, in practice the implementation of MACRA has not proven to be the fix that was promised. While the law helped address the short-term physician payment issues caused by the SGR, for the last several years the Medicare Trustees Report has reiterated that there remain "…important long-range concerns that will almost certainly need to be addressed by future legislation."[1] These concerns include specified payment updates not accounting for varying economic factors, including not keeping up with the pace of inflation and failing to rectify increasing gaps between the payment updates and growing physician costs. Given these concerns, the Trustees expect "…access to Medicare-participating physicians to become a significant issue in the long term."

We believe that with improvements developed in collaboration with Congress, regulators, and stakeholders, MACRA (or a subsequent framework) can be significantly

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[1] https://www.cms.gov/files/document/2025-medicare-trustees-report.pdf

more effective in facilitating a successful transition to value-based care delivery. It does not necessitate the wholesale dismantling of the current system as we did with the SGR, but does require more regular oversight and better integration of the varying specialties as meaningful participants in the process. This will help us develop a more viable and stable payment system that truly incentivizes high-quality, cost-effective care. To this end, ACEP responded to a recent bipartisan request for information from the House GOP Doctors Caucus and Congressional Doctors Caucus, detailing some of our proposals on legislative reforms needed to improve, modernize, and stabilize the Medicare physician payment system, and we appreciate their ongoing efforts to drive needed change.

Financial stability and certainty are critical in ensuring that Medicare can fulfill its promise to the millions of American seniors that deserve and depend upon this program. The annual issue of significant Medicare physician payment cuts not only threatens the viability of the health care safety net but also affects our ability to effectively partner with Congress to address other critical challenges facing the physician community, and most importantly, our ability to advocate on behalf of our patients. We share legislators' significant frustrations with the perennial task of finding costly, short-term fixes for long-term problems, and we support efforts to provide greater stability and certainty in the Medicare system and thank you once again for the Committee's attention to this critical issue.

Growing Financial Pressures and Unique Concerns for Emergency Medicine

Emergency physicians serve on the front line of the health care system and provide care under circumstances and laws that are unique among other physician and provider specialties. Both by oath and under the federal Emergency Medical Treatment and Labor Act (EMTALA), emergency physicians provide lifesaving emergency care to every patient regardless of their insurance status or ability to pay. As a result, we provide more uncompensated care than any other physicians or providers, and combined with growing financial and operational pressures, the health care safety net we provide is under increasing strain.

The burden of uncompensated care only continues to grow, particularly in communities with high populations of uninsured patients. A report issued by RAND in April 2025, "Strategies for Sustaining Emergency Care in the United States,"[2] brings this uncompensated care burden into sharp relief – across all payers, **20 percent of emergency physician payments go unpaid, representing $5.9 billion in annual losses**. Additionally, in order to ensure 24/7/365 access to the emergency department (ED), we work under more specialized staff and standby requirements than other types of medical providers so that we can meet the needs of patients who experience a wide range of emergencies every day, such as heart attacks, strokes, trauma, mental health conditions, and countless others.

Declining payments for emergency services further compound the financial pressure on emergency medicine. From 2018-2022, commercial insurance payments to emergency physicians dropped 10.9 percent in-network and 47.7 percent out-of-network. Medicare and Medicaid payments per visit also dropped 3.8 percent during the same period. Together, Medicare and Medicaid account for more than 65 percent of ED visits (33.6 percent and 32 percent, respectively), so the cumulative impact of continued reimbursement cuts in federal programs alone has a disproportionate effect on emergency medicine. Additionally, harmful payer reimbursement practices such as those detailed in ACEP's statement for the record for recent congressional hearings with insurance company executives, as well as growing health care consolidation, not only add financial burdens but are also major sources of stress and burnout for emergency physicians.

Necessary Structural Improvements for the Medicare Physician Payment System

ACEP strongly supports efforts to stabilize the Medicare physician payment system, including:

[2] https://www.rand.org/pubs/research_reports/RRA2937-1.html

- Establishing a permanent inflationary update based upon the Medicare Economic Index (MEI), such as the bipartisan "Strengthening Medicare for Patients and Providers Act" (H.R. 6160) led by Representatives Raul Ruiz, MD (D-CA) and Gus Bilirakis (R-FL).
- Implementing improvements and updates to the Physician Fee Schedule's (PFS) budget neutrality rules to mitigate year-to-year fluctuations in the conversion factor, such as those proposed in the "Provider Reimbursement Stability Act" (H.R. 8163) led by Representatives Greg Murphy, MD, and Jimmy Panetta (D-CA).
- Modernizing and improving the Medicare and CHIP Reauthorization Act of 2015 (MACRA) to assist in the transition toward more value-based payment models and reduce clinician burdens.

We also ask Congress to act before the end of the year to prevent any potential cut that may result from possible negative budget neutrality adjustments in the upcoming calendar year (CY) 2027 PFS rule and the expiration of temporary relief provided by Congress through the end of 2026.

Modernizing MACRA: Improving the Merit-based Incentive Payment System (MIPS)

Broadly, MACRA as implemented is a "one-size-fits-all" approach for physicians and other clinicians, regardless of specialty or practice model, thereby ignoring core differences between different modalities of care. A truly transformative, value-based payment system must recognize and be able to encompass different models of care:

- Non-episodic/scheduled care (primary care including chronic/longitudinal care management)
- Episodic/scheduled care (typically elective procedures, mostly specialty care)
- Episodic/unscheduled care (emergency care, urgent care

CMS tried to address this one-sized-fits-all constraint through the creation of the MIPS Value Pathways (MVPs). Under this optional approach, clinicians can report on a uniform set of measures on a particular episode or condition in order to get MIPS credit. ACEP developed an emergency medicine-focused MVP that CMS included in the first batch of MVPs starting in 2023. While we appreciate the implementation of our Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, we are generally concerned that based upon the reporting trends from its first performance year of 2023, there is limited uptake; likely as there are still not sufficient incentives to encourage clinicians to report through this MVP. Clinicians who report MVP data also have the option of reporting through Traditional MIPS, and CMS takes the highest score. Based on the first year of data, not only did only a small number of clinicians report through MVPs, but most who did also chose to report Traditional MIPS. These clinicians received a higher score overall in Traditional MIPS than in MVPs. For the emergency medicine MVP, 2,912 clinicians registered to report the MVP and 1,112 reported MVP data-- but only 45 clinicians received a final score from the MVP in the 2023 performance year. It is still too early to tell whether participation will increase and whether the MVP approach is a viable pathway for MIPS going forward.

There are some structural flaws within MVPs that may also be leading to low participation rates. There are no additional financial incentives for participating in an MVP – and since clinicians are generally performing better in Traditional MIPS than MVPs anyway, it may not be worthwhile for clinicians to spend additional time and effort to report to an MVP.

To help ensure MACRA's success, we ask Congress to consider refining MIPS overall, including the MVP approach established by CMS, in order to better tailor the program to the type of care a physician actually typically delivers. For example, there could be a system in which primary care continues to use traditional quality and cost measures, scheduled care could use episodes-of-care and MVP measures, and emergency care could use its own paradigm, relying on more relevant measures like the EM cost measure with a 14-day episode (as opposed to 30-day for other specialties). Such a system would better reflect the type of work a physician performs the majority of the time.

Further, the clinician community believed when MACRA was passed that the ultimate goal was for most clinicians to transition away from MIPS to participate in Advanced APMs. Besides there not being opportunities for most specialists to participate in Advanced APMs, there should also be better, and more sustainable incentives to participate in these models.

As it stands, MIPS is currently set up for larger groups to perform well and may be a more attractive and financially viable option as there is less risk, which suggests that there should be better incentives to encourage larger groups to participate in Advanced APMs. And while MIPS is burdensome, the development of quality measures requires significant effort, time, and resources, and we do not want those to simply go away. Qualified clinical data registry (QCDR) measures should still be used – they have been refined and maintained, are specialty-specific, and have been developed for the sole purpose of improving care for patients seen by such specialists.

QCDRs are third-party intermediaries that help clinicians report under MIPS, and they have proven to be an excellent way to collect data and report quality measures. ACEP developed its own QCDR, the Clinical Emergency Data Registry (CEDR), offering dozens of EM-specific measures and QPP measures spanning five domains of care. QCDR measure owners invest significant resources into measure development, data collection, and validation. Additionally, QCDR measure owners develop these measures for use beyond MIPS reporting (e.g., research, guideline development, quality improvement, etc.). Section 1848(q)(5)(B)(ii)(I) of the Social Security Act, as added by Section 101 of MACRA requires HHS to encourage the use of QCDRs to report quality measures under MIPS. In line with this statutory requirement, ACEP has urged CMS to continue refining the QCDR option under MIPS to streamline the self-nomination process and provide better incentives for organizations, including medical associations such as ours, to continue to invest in their QCDRs and develop new, meaningful measures for specialists to use for MIPS reporting and other clinical and research purposes. Conversely, CMS should refrain from finalizing proposals that would impose significant and unreasonable burdens on QCDRs, **and we strongly urge the Committee to ensure that registries like CEDR can continue to succeed and be developed further**.

Modernizing MACRA: Expanding APM Pathways & Integrating Specialty Care

To ensure APMs deliver real improvements in cost and quality while ensuring successful scaling of innovations, we urge Congress to consider a range of options to examine why specialists, including emergency physicians, have largely been precluded from participating in APMs.

As they treat each patient, emergency physicians must make a critical decision about whether the patient should be kept for observation, admitted as an inpatient to the hospital, or discharged. Essentially, they act as a gateway to the hospital for many patients. Emergency physicians are therefore in a prime position to be meaningful participants in APMs that attempt to shift our health care system to one that rewards value over volume. However, while many emergency physicians are ready to take on the downside risk and participate in Advanced APMs, there simply are not any opportunities to do so.

For context, in order to address the gap in available Advanced APMs for emergency physicians, ACEP established an internal APM Task Force to review various APM proposals, eventually resulting in the development of an emergency medicine-focused APM, the Acute Unscheduled Care Model (AUCM; affectionately pronounced "awesome"), that we have presented to regulators for incorporation into various APM initiatives. In October 2017, ACEP submitted the AUCM proposal to the PTAC. Established by MACRA, the PTAC is tasked under statute with commenting on and recommending physician-focused APM proposals to the Secretary of Health and Human Services

(HHS) for consideration, based on a set of ten criteria established by the Secretary. After months of discussions with a Preliminary Review Team (PRT) within the PTAC, ACEP officially resubmitted the model in June 2018.

In September 2018, three emergency physicians presented the model to PTAC during a public meeting. PTAC voted on the ten criteria and determined that the AUCM proposal met all ten criteria.

PTAC Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary	**Full PTAC Rating**
1. Scope (High Priority)	Meets and Deserves Priority Consideration
2. Quality and Cost (High Priority)	Meets
3. Payment Methodology (High Priority)	Meets
4. Value over Volume	Meets
5. Flexibility	Meets
6. Ability to be Evaluated	Meets
7. Integration and Care Coordination	Meets
8. Patient Choice	Meets
9. Patient Safety	Meets
10. Health Information Technology	Meets

The PTAC then voted to submit the model to the HHS Secretary for full implementation, agreeing that the model has great potential to improve the way emergency care is delivered and that it fills a huge gap in the current portfolio of APMs. One member of the PTAC even stated that it was the best APM that they had reviewed to that point. Based on the vote and recommendations made during this meeting, PTAC then formally issued a report to the HHS Secretary in October 2018 stating that AUCM deserves priority consideration based upon the scope criterion.

In September 2019, HHS Secretary Alex Azar responded[3] to the PTAC's recommendation by stating that he was, "interested in exploring how the concepts in the AUCM model for care management by emergency physicians after an ED encounter could be incorporated into models under development at the CMS Center for Medicare and Medicaid Innovation (CMMI)." But despite subsequent conversations with) CMMI has not made any tangible progress on the implementation of the model at this point.

ACEP has repeatedly raised our concerns with CMS that the agency is not doing enough to engage emergency physicians in value-based payment initiatives. For example, in our response to the CY 2026 PFS and QPP proposed rule, ACEP reiterated our call that CMS prioritize the creation of additional APM opportunities for emergency physicians and other specialists, or determine how to modify existing APMs to better engage specialists and allow them to actively participate.

At this point, with little action from CMS on the AUCM, we are working with other payers beyond Medicare to try to advance the model's core principles – including Medicaid and private payers. As these payers continue to move away from traditional fee-for-service (FFS) contracts toward value-based payment arrangements, the AUCM could be an ideal APM construct for them to adopt, at least in terms of core concepts. We anticipate that some features of these private payer APMs will be different from the AUCM depending on the specifics and needs of the targeted patient population.

ACEP encourages Congress to consider legislative options including giving more weight or authority to recommendations made by the Physician Payment Technical Advisory Committee (PTAC); mandating that CMMI

[3] https://downloads.cms.gov/files/ptac-hhssecresponse-sep18-dec18.pdf

implement new models that have been recommended for adoption by the Secretary of the Department of Health and Human Services (HHS); or, at minimum, ensuring greater transparency by requiring CMMI to report to Congress why models that have been approved or recommended for adoption have not been implemented (such a report should be retroactive to encompass all models that have already gone through this process). We also urge Congress to exercise its critical oversight role to examine why emergency physicians and other specialists have largely been precluded from participating in APMs.

Refining PFS Policy Changes to Limit Unintended Consequences

In the calendar year (CY) 2026 Medicare PFS, CMS finalized two policies that, while well-intended, do not account for the needs or realities of emergency medicine.

- **Efficiency Adjustment**: CMS finalized a 2.5 percent "efficiency adjustment" for work relative value units (RVUs) and physician intra-service time for all non-time-based codes, with additional reductions expected every three years indefinitely. This policy was based on the assumption that all non-time-based services become more efficient as those services become more common, professionals gain more experience, technology improves, and other operational improvements are implemented; however, the across-the-board methodology applied by CMS does not differentiate between services that can realize efficiencies and those that cannot, or services that have already recently undergone evaluation through existing processes. Further, advances in technology do not necessarily directly reduce the time it takes to conduct specific services and interpret results.

  Though the vast majority of emergency medicine services evaluation and management (E&M) codes are not subject to the efficiency adjustment, procedures frequently performed by emergency physicians are. These include things like ultrasounds, laceration repairs, fracture care, CPR, burn treatment, intubation, among many others. Intubation, for example, is already as efficient as possible – it is a difficult procedure that has life-or-death implications. CPR is also not an expensive or overly-inflated procedure meriting an efficiency adjustment.

  While we share CMS' goal of ensuring that PFS valuations accurately reflect changes in resource use over time, we believe this policy should at least be refined to incorporate service-specific analysis and should exempt codes that have recently been revalued. Further implementation of the policy should also be delayed to allow specialty societies to provide input on where efficiencies are achievable and where the nature of the service precludes such gains.

- **Indirect Practice Expense (PE) RVU Reallocation**: CMS also finalized a policy to reduce indirect PE RVUs in the facility setting to 50 percent of the amount used in the non-facility setting (exempting maternity care codes with an MMM global period). Indirect PE is a part of the Medicare PFS intended to account for overhead and other costs, such as rent, equipment, utilities, administrative staff, and other costs.

  In the rule, CMS acknowledged that physicians practicing in facility settings may still incur indirect PE costs, and further acknowledged that facilities may incur higher overhead costs because they must be equipped and able to furnish services 24 hours a day and 7 days per week under EMTALA. However, the rule was finalized largely as proposed and without any of the exceptions or refinements that ACEP and other organizations had requested.

  CMS believes that because fewer physicians who primarily work in facilities still own their practices, their indirect PE costs do not need to be the same as those physicians who work in non-facility settings. The intent of the policy to preserve private practice and prevent further integration and consolidation is well-meaning and is a goal that ACEP strongly supports. However, this policy also does not account for the unique practice considerations for most emergency physicians.

Most emergency physicians are not employed directly by hospitals, but instead provide services in hospitals as a group through contracts for their professional services. They operate independently and have their own set of operating expenses. CMS' Indirect PE reduction does not account for the variations in sizes, structures, and associated operating expenses of practices like these. It also disproportionately affects emergency medicine – while other clinicians and specialties may provide E/M services in non-facility settings (or a mixture of facility/non-facility), emergency physicians mainly perform evaluation and management (E/M) services that are exclusively provided in the facility setting. This reallocation treats a group's fixed costs as if the hospital has absorbed them simply because the care occurs in a facility – i.e., physician payment is reduced though the physician's costs have not changed.

Again, we share CMS' goal of preserving independent physician practice but believe this policy will have the opposite effect. Independent groups, especially smaller practices, will see shrinking reimbursement while their costs remain the same (or grow), which will exacerbate the pressures accelerating consolidation, ultimately putting ED coverage and timely access to lifesaving care at risk. We believe the intent of this policy can still be met with appropriate refinements, whether simply differentiating between those directly employed by the hospital or not (e.g., establishing a modifier to indicate employment) or at the very least excluding certain E&M and critical care services from the reduction.

We look forward to working together with Congress to identify substantive long-term reforms, and urge you to hold hearings and convene stakeholder roundtables to explore potential solutions that will guarantee the stability and security of the Medicare program, ensuring our nation's seniors have access to the high-quality care they need and deserve.

Once again, thank you for your attention to the issue of physician payment reform and for the opportunity to share our comments with you. We look forward to working together with you to develop potential solutions that will guarantee the long-term stability and security of the Medicare program, ensuring our nation's seniors have access to the high-quality care they need and deserve. Should you have any questions or need any additional information, please do not hesitate to reach out to Ryan McBride, ACEP Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

L. Anthony Cirillo, MD, FACEP
President, American College of Emergency Physicians

Statement of the American College of Surgeons
to the Committee on Energy & Commerce
Subcommittee on Health
United States House of Representatives
RE: Examining the Medicare Physician Fee Schedule, MACRA,
and Opportunities for Payment Reforms
May 20, 2026

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On behalf of the more than 96,000 members of the American College of Surgeons (ACS), thank you for convening the hearing, "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms." The ACS remains committed to ensuring the highest quality of care for all surgical patients, including Medicare beneficiaries, and we appreciate the opportunity to discuss some areas within the Medicare reimbursement system that could be improved in order to ensure access to high-quality surgical care for all American seniors.

We thank Congress for its efforts to address short-term instability in the Medicare Physician Fee Schedule (MPFS) over the last few years, as well as the Health Subcommittee's attention to broader reform of the Medicare Access and CHIP Reauthorize Act (MACRA). Federal policy should enable surgeons of all specialties, in all practice settings, and in all career stages, to provide the best possible care for their patients while leading full and productive personal and professional lives. The ACS is committed to working with Congress to stabilize the physician fee schedule as well as reform MACRA to better realize the goal of value-based care.

Identifying Structural Problems Within the Medicare Physician Payment System

Quality has been the cornerstone of the ACS since its founding more than 110 years ago, and the ACS continues to provide accreditation and verification programs, products, guidelines, and tools to improve surgical quality. But optimal quality, the centerpiece of the ACS' mission, is not achievable without optimal access. Unfortunately, recent regulatory changes to the MPFS have systematically devalued surgical care, threatening patient access to critical services. In addition, long-term structural challenges persist within the payment system and with implementation of MACRA.

Instability within the MPFS threatens the viability of physician practices and erodes quality improvement efforts. Over the last few decades, Centers for Medicare & Medicaid Services (CMS) policies have resulted in broad and arbitrary cuts, repeatedly to the MPFS conversion factor, and more recently, to the work Relative Value Units (RVUs) and intra-service time for all non-time-based codes. These repeated cuts are often an unintended consequence of statutory budget neutrality requirements of the MPFS, which pit physicians against one another as resources must be taken away from certain physician services to finance others.

A zero-sum payment system is counterproductive as it forces all specialties to compete for increasingly scarce resources while failing to incentivize high-quality care or effective care coordination. The ACS is grateful to Congress for mitigating recent cuts by providing 2.5% conversion factor relief for 2026 as part of H.R. 1. However, if Congress does not act, this one-time fix will expire at the end of the year and create yet another cut to reimbursement on January 1, 2027.

Moreover, the MPFS remains the only Medicare payment system that is not indexed for inflation. Physicians saw their Medicare reimbursement decrease by 15.5% in real terms between 2001 and 2025 while practice expenses such as rent, equipment, staffing, and utilities have increased. Surgeons and other physicians have also seen an increase in financial pressures to meet new bureaucratic barriers such as increased use of prior authorization in Medicare Advantage.

In addition to these financial pressures, failures in the implementation of MACRA have hindered the transition to value-based care. Since the enactment of MACRA in 2015, the ACS has made significant investments to translate what we have learned about improving quality of care and outcomes into proposals to increase value for surgical patients. Our efforts have included:

- Early leadership and ongoing work in surgical alternative payment model (APM) development, including submission of one of the first Advanced APM proposals to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The ACS has continued to offer constructive feedback and advice to CMS and the Center for Medicare and Medicaid Innovation (CMMI) on how best to accommodate specialists eager to participate in value-based care;

- Development of the CMS *Age-Friendly Hospital Measure*, a novel programmatic quality measure finalized in the CMS Inpatient Quality Reporting (IQR) program that incentivizes patient-centered, goal-concordant, team-based care organized around the geriatric hospital patient; and

- Development of the *ACS CollaboRATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients* measure to assess the quality of patients' shared decision-making for surgery in the ambulatory setting to improve patient-centricity, patient outcomes, and unnecessary care.

Yet today, many surgeons still struggle with the same barriers to improving outcomes and transitioning to modern payment systems that they did a decade ago:

- Surgeons were faced with a 2.5% reduction to work RVUs in 2026 in addition to reductions in facility-based practice expense RVUs earned for procedures performed outside an office setting;

- The combined effect of inflation and the absence of physician fee schedule updates to reflect rising practice costs has made care more expensive to deliver even as payment rates continue to decline;

- Most physicians in fee-for-service (FFS) are still evaluated based on measures that do not assess care delivered to their patients or the conditions they treat, meaning no information is available for improvement efforts or for patients and referring physicians to make care choices; and

- Many surgeons wishing to move beyond FFS will find few physician-focused APMs are available for them. Current options are largely mandatory and some limit the ability of interested parties to opt-in. This is compounded by the failure to test voluntary, physician-directed models approved by the PTAC.

MACRA was intended to fix problems in the previous reimbursement landscape and transition to a value-based care system. However, many structural barriers remain. Under current law, and assuming no additional cuts result from budget neutrality or other policy decisions, it would take decades for the MPFS conversion factor to return to the same amount it was in the year 2000. Over that same period, inflation will have significantly eroded the value of payments. Clearly, this is not tenable. The ACS is concerned that ongoing systemic challenges, coupled with the persistent devaluation of surgery within the MPFS, will jeopardize access to surgical services in the future.

I. Addressing the Devaluation of Surgical Care

Stop Implementation of CMS' Flawed Efficiency Adjustment

In order to ensure that Medicare patients maintain access to the full spectrum of health care services, Congress must first address the recent cuts to procedural codes that took effect January 1, 2026. This most recent cut disproportionally affects surgical and other procedural specialties and illustrates the broader structural issues that force physicians to fight over limited resources.

The latest action by CMS reduces the work RVUs and intra-service time for all non-time-based codes by 2.5% in 2026, with additional reductions expected every three years indefinitely. This "efficiency adjustment" is intended to address an incorrect assumption that non-time-based services become more efficient as the services become "more common, professionals gain more experience, technology is improved, and other operational improvements are implemented."[1] In direct contradiction to this claim, a recent peer reviewed study published in the *Journal of the American College of Surgeons* analyzing more than 1.7 million operations, spanning 249 CPT codes and 11 surgical specialties, found that 90% of CPT codes had the same or longer operative times in 2023 compared to 2019.[2]

The policy from CMS assumes longitudinal efficiency for an individual physician and proposes the adjustment be applied in a cross-sectional manner to all non-time-based codes, including those that have been recently revalued. Adding to the flawed implementation of this policy, the 2.5% reduction was calculated using only the productivity component of the Medicare Economic Index (MEI), which is not a valid measurement of physician-specific productivity, given that the MEI is based on changes in economy-wide productivity and does not reflect physician work. While the MEI could be useful in accounting for the rising cost of care delivery, unfortunately, there is no automatic inflationary adjustment to account for these increased costs, based on MEI or otherwise, included in the MPFS, and the productivity component of the MEI on its own is meaningless.

This policy is based on the premise that services will continue to become more efficient indefinitely, and that all physicians experience the same rate of efficiency, which is flawed. While advances in medical technology and treatment protocols allow more patients to survive severe illnesses, these same patients often later require complex, high-risk procedural intervention. Highly experienced physicians may improve time efficiency, but undertake the most challenging cases, whereas newly trained or teaching physicians may treat less complicated patients but typically require more time. Valuation is based on time and complexity/intensity—not just time alone.

Further, a recurring reduction in work RVUs every three years will have severe consequences for physician compensation, even beyond direct reimbursement from the MPFS. Many physician employment contracts are based on work RVUs or total RVUs, meaning that reductions in these values will decrease physician compensation despite no reduction in actual work performed. The inability to anticipate the magnitude of RVU reductions introduces ongoing uncertainty, making it increasingly difficult to structure fair and sustainable employment agreements, while extending another layer of financial unpredictability for private practice and solo practitioners. The likely response to this instability may be further consolidation.

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[1] 90 FR 32352

[2] Childers CP, Foe LM, Mujumdar V, et al. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. *J Am Coll Surg*. 2025.

For surgeons, this efficiency adjustment is not a technical coding issue. It is a direct payment cut layered on top of years of instability in the MPFS. It will disproportionately affect procedural and surgical care, including general surgery, where Medicare payment reductions already threaten access in communities facing shortages. **The ACS is grateful to Representatives Ron Estes and Tom Suozzi for introducing H.R. 7520, the Efficiency Adjustment Delay Act, to stop this cut and require CMS to provide clinically relevant data before implementing a one-time efficiency adjustment in the future. We urge Congress to include this legislation in boarder Medicare payment reform proposals.**

Appropriately Value Surgical Global Codes

The recent reduction applied to procedural codes is compounded by years of declining value of surgical global codes. Global codes bundle preoperative, intraoperative, and postoperative care into a single payment, limiting separate reimbursement for related services. In the calendar year (CY) 2021 MPFS final rule, CMS increased the values for office and outpatient Evaluation and Management (E/M) visits but failed to apply corresponding adjustments to the E/M services included within global surgical codes.[3] Similarly, when the Agency approved increases to hospital inpatient and observation services for CY 2023, the corresponding adjustments within global surgical codes were not applied.

This deliberate departure from precedent in CYs 2021 and 2023 resulted in a disproportionate devaluation of global codes and created specialty-specific payment inequities that run contrary to Medicare statute. The ACS is concerned that by not incorporating this increased valuation of E/M codes into global surgical packages where similar services may be delivered as part of a patient's surgical case, the longitudinal care provided by surgeons is undervalued. **We continue to advocate for more accurate alignment between E/M valuation and the global codes to ensure high-quality surgical care is recognized.**

Reverse Facility-Based Practice Expense Changes

The CY 2026 MPFS final rule also included a reduction to indirect practice expense (PE) RVUs for facility-based services. This change is based on a flawed assumption that facility-based indirect PE payments may result in "double counting" when hospitals employ physicians, as some of these overhead costs may already be reflected in separate facility payments under the Outpatient Prospective Payment System. However, given that employed physicians never receive this facility fee, they are not the beneficiary of this perceived imbalance. Furthermore, CMS imposes this policy on all physician services furnished in the facility setting, regardless of the physician's employment status or practice structure. The result is a shift in reimbursement from the facility to the non-facility setting – estimated at -7% in facility settings and +4% in non-facility settings.

This change may result in increased payment for certain physicians billing office visits in the non-facility setting despite being employed by a hospital, in direct contradiction to CMS' stated intent. Additionally, it creates a perverse financial incentive for hospitals to consolidate by acquiring independent physician practices and shifting more services into the non-facility setting where higher payments may apply. Such a shift would accelerate the ongoing trend of market consolidation, reduce competition, and further inflate costs for patients. **The ACS believes that any savings CMS achieved by addressing perceived duplicate indirect PE payments should not be reallocated to non-facility PE RVUs. Instead, such savings should be redistributed via a budget neutrality adjustment to the MPFS conversion factor to**

[3] Childers CP, Hu CY, Swisher SG, Wong SL, Chang GJ. Estimated Financial Impact of 2021 Office-Visit Work Relative Unit Updates on Surgical Global Periods. *JAMA Surg*. 2024;159(9):1087-1089.

maintain relativity across all specialties and settings, rather than inflating payments selectively for non-facility services.

Medicare Reimbursement Has Declined and Practice Costs Have Risen

Recent Medicare reimbursement changes must be understood in the broader context of physician payment system instability. The MPFS conversion factor has declined over the last several years, even as the cost of running a surgical practice has increased.

Calendar year	Medicare Physician Fee Schedule conversion factor	Notes
2021	**$34.89**	Revised CY 2021 conversion factor after congressional action.
2022	**$34.61**	Updated CY 2022 conversion factor; lower than 2021.
2023	**$33.89**	Updated CY 2023 conversion factor after congressional relief.
2024	**$32.74 initially; later adjusted for part of the year**	CMS listed the CY 2024 conversion factor as $32.74 for Jan. 1–Mar. 8, with a later statutory update applying for Mar. 9–Dec. 31.
2025	**$32.35**	Final CY 2025 conversion factor.
2026	**$33.57 for qualifying APM participants; $33.40 for non-qualifying APM participants**	CMS finalized separate 2026 conversion factors under current law. The conversion factors increased due to *temporary c*ongressional relief, pre-existing statutory adjustments, and budget neutrality effects of the efficiency adjustment.

From 2021 to 2025, the conversion factor fell from $34.89 to $32.35, a decline of approximately 7.3%. Even with the 2026 statutory increase, the non-qualifying APM conversion factor of $33.40 remains about 4.3% below the 2021 level. And this increase masks reductions felt by many physician specialties affected by CMS policies including the efficiency adjustment.

That decline does not account for inflation, staff costs, rent, supplies, medical liability coverage, health information technology, compliance costs, or the cost of maintaining 24/7 surgical readiness. For general surgeons, who often provide emergency care, trauma coverage, endoscopy, abdominal surgery, cancer-related procedures, and essential backup for rural hospitals, this instability creates mounting pressure. Congress has repeatedly stepped in to mitigate scheduled cuts on a yearly basis, but temporary patches do not give surgical practices the predictability needed to recruit staff, maintain call coverage, invest in quality improvement, or remain financially viable in underserved communities.

II. Stabilizing Medicare Reimbursement

The ACS is committed to working together with Congress to ensure the stability of the MPFS through both short and long-term policy improvements. While 2026 is the first year where positive statutory updates are included in the MPFS, this positive adjustment is outweighed by years of devaluation. Current law provides a 0.25% conversion factor update for non-APM participants and a 0.75% update for qualified Advanced APM participants, still failing to adequately offset the effects of inflation and account for rising medical and staff costs. Without congressional action, continued cuts will challenge physicians to provide adequate services and high-quality care. Additionally, without an inflationary update for the MPFS, it is unlikely that future payments will keep pace with medical costs.

ACS supports building an update into the MPFS, comparable to other Medicare payment programs, to account for the effects of inflation on the cost of providing care to seniors as a starting point to create a more stable foundation for value-based care initiatives. This inflationary update should be separate and distinct from incentives for quality and from the budget-neutral Merit-based Incentive Payment System (MIPS) incentives. **One potential solution would be H.R. 6160, the Strengthening Medicare for Patients and Providers Act, introduced by Representatives Raul Ruiz, MD and Gus Bilirakis. This legislation would provide an inflationary update to the MPFS based on MEI.**

The impact of the lack of inflationary adjustments is further compounded by the overly strict nature of the budget neutrality trigger. The budget neutrality requirement in a system with no inflationary updates results in across-the-board cuts for any changes to the MPFS expected to increase expenditure by as little as $20 million annually. This trigger amount has remained the same since its implementation in 1992. Updating the trigger for budget neutrality adjustments would help to ensure that comparatively minor changes to relative values or the addition of limited new service codes do not always require across the board cuts. **Congress, at a minimum, should amend 42 USC 1395w-4 (c)(2)(B)(ii) to increase the current $20 million budget neutrality adjustment trigger and index it for inflation going forward**. **The ACS thanks Representative Greg Murphy, MD for introducing H.R. 8163, the Provider Reimbursement Stability Act of 2026, to reform the budget neutrality mechanism.**

III. Improving MACRA to Ensure Meaningful Quality Measurement and Reduce Reporting Burden

The passage of MACRA was necessary to remove the threat of the sustainable growth rate and combine the competing requirements of multiple measurement programs into a single program. However, over the past decade of implementation, it has become clear that the program lacks the flexibility to accommodate innovation in measurement science, technology, and modern approaches to incentivizing value-based care arrangements. Efforts to reform the program such as the move to MIPS Value Pathways have suffered from the same lack of flexibility, resulting in compromise solutions that fail to fully solve underlying problems with the system. If Congress seeks to improve Medicare physician payment, they must empower or direct the agency to break out of the constraints of the current program and rethink how we define and measure quality. Below are some suggestions based on the ACS' experience with verification and building quality programs.

Adopt Programmatic Measures

The ACS sees quality as a comprehensive program built around the patient, and inclusive of the entire team involved in providing care for patients with a given condition or diagnosis. The current model of individual,

disconnected measures is insufficient to achieve coordinated, patient-centered, high-value care and provides little actionable information for physician improvement or patient decision making when it is time to seek care. This is especially true in rural and under-resourced areas where regional shortages in surgeons and other care providers can lead to reduced access and fewer choices for care.

Most physicians in the current FFS system are evaluated on measures that do not reflect the care they deliver to patients or the conditions they treat. Further, the payment update associated with the reported data applies two years after the data has been reported. This means that no actionable, recent information is available for improvement or to help patients choose the best care for them. In contrast, the ACS has designed quality programs to overcome barriers faced by surgeons and other physicians who want to work together to coordinate and improve care. Based on these efforts and the more than 100-year history of the ACS working to improve the quality and value of care for surgical patients, the ACS believes addressing the shortcomings of traditional Medicare FFS payments will require new types of quality measures, facilitated by increased flexibility in participation and scoring options in MIPS. As described below, such a combination will improve care coordination and reduce surgical complications.

The ACS believes that we must refocus on the patient by incorporating shared decision-making and patient goal identification for goal-concordant care. To deliver on patient goals, it is critical that a verified quality program is in place, ensuring the right structures, processes, and personnel. All of this information should be transparently portrayed to help patients find and access such care. **ACS Verification programs, such as the Quality Verification Program (QVP) and the Geriatric Surgery Verification (GSV) Program, are examples of programs that align care teams around the needs of patients**. The framework used in these ACS Verification Programs is the basis of "programmatic measures," which more accurately assess the ability of a system to provide high-quality care to patients. Programmatic quality measures do the following:

- Align multiple structures, processes, and outcome measures, including patient-reported outcomes;
- Focus on shared decision-making and goal concordant care;
- Target condition or population specific care;
- Apply to multiple quality domains;
- Follow the continuum of care; and
- Create actionable quality improvement information for care teams.

Our experience with programmatic measures exhibits applicability to diverse care settings, limited burden on care providers, and demonstrably better results. Applied correctly, programmatic measures will address the quality gaps created by the current measures and ensure surgical care is measured appropriately.

Expand Scoring Options

The ACS also supports greater flexibility in how physicians and teams are measured. Under the current MIPS framework for example, we have supported expanding the existing facility-based scoring option by including more facility settings and reporting programs and applying it to all four MIPS categories (to include Promoting Interoperability and Improvement Activities, in addition to Quality and Cost as currently

in statute). Allowing for facility-based scoring and measurement in an FFS framework is in line with the ACS perspective on programmatic quality programs and is more closely aligned with how patients experience care.

A framework of shared measurement between facilities and physicians could greatly aid in care-coordination, especially when coupled with programmatic measures such as the *Age-Friendly Hospital Measure* included in the IQR program. Such a change should not appreciably increase costs because physicians would continue to be updated through the largely budget neutral MIPS program.

The ACS developed programs like GSV and QVP have demonstrated marked improvements in patient care in trauma, cancer, bariatric surgery, geriatric surgery, and other areas, all of which involve the clinical team and facilities coming together to improve the delivery of care. Alignment with facility reporting is critical for care centering the patient. **We believe a voluntary expansion of facility-based scoring to additional physicians, sites of service, and to all MIPS categories would be an important incremental step toward better coordinated value-based care. It would also greatly reduce reporting burden while creating the environment necessary for meaningful quality programs to be recognized and incentivized in the FFS payment environment.**

Engage Physician Stakeholders in APM Development

The ACS supports building a more modern care environment for patients, rewarding value and innovation. Medicine should be moving steadily toward a system that truly rewards the value of care provided rather than data entry that may have little relevance to the patients being treated, while ensuring access to high-quality care across all settings. This could partially be achieved through testing and expansion of APMs developed by and for specialists.

CMMI has recently taken important steps to expand APM opportunities for specialists such as the newly implemented Transforming Episode Accountability Model, which focuses on five categories of surgical care, and the upcoming Long-term Enhanced Accountable Care Organization (ACO) Design model, which includes CMS-Administered Risk Arrangements specifically to make it easier for ACOs to bring specialists into value-based care. These represent steps in the right direction but could be improved through greater outreach to specialty societies and physicians treating the affected patient groups. In addition, limiting innovation to CMS designed models is slowing progress. **Congress should encourage innovation by incentivizing the testing and implementation of physician-developed, value-based payment models. Models developed by subject matter experts such as specialty societies will be better structured to provide and utilize timely, actionable data and allow physicians to improve care.**

Congressional Action is Needed to Reform Medicare Payment: In Summary

Medicare physician payment reform is urgently needed. While the value-transformation is underway, it could greatly benefit from improving the foundation of the physician fee schedule as well as efficient investments in the partnership between CMS and stakeholders interested in improving the way quality is measured and incentivized. Congress has the opportunity to address recent misguided changes to physician reimbursement, as well as provide CMS with direction, flexibility, and additional authority to help achieve the goal of improving value. The ACS proposes the following specific action items for Congress to consider:

- Stop the 2.5% efficiency adjustment enacted in 2026 and future pending cuts;

- Implement an update mechanism in the MPFS to account for inflation. This will create a stable base from which physicians can make the leap to models involving risk;
- Eliminate the MPFS budget neutrality requirement or increase the trigger threshold and index it annually to account for inflation;
- Direct CMS to partner with stakeholders to test physician-developed APMs, such as those recommended previously by the PTAC; and
- Create flexibility for shared measurement and accountability in MIPS, such as through expansion of facility-based scoring.

It is critical that Congress take steps to stabilize the Medicare physician payment system, build upon MACRA's vision of value-based care, and ensure the appropriate valuation of surgical services. Federal policy should support all physicians to provide the best care for their patients in the most appropriate setting, not pit specialties against one another, or perversely incentivize consolidation. Medicare reimbursement must account for the rising cost of providing care, the increasing medical complexity of an aging population, and the essential role that physicians play in their communities.

Surgeons are committed to being part of the solution, and the ACS looks forward to continuing to work with Congress to advance these critical and necessary reforms. Thank you for convening this important hearing and for the Subcommittee's commitment to our shared goal of ensuring access to high-quality, affordable care for all Americans.

For questions or additional information, please contact Emma Zimmerman with the ACS Division of Advocacy and Health Policy at ezimmerman@facs.org.

ACS Statement on the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms

Quality has been the cornerstone of the American College of Surgeons (ACS) since its founding more than 110 years ago. But optimal quality, the centerpiece of the ACS' mission, is not achievable without optimal access. Recent regulatory changes to the Medicare physician fee schedule (MPFS) have systematically devalued surgical care, threatening patient access to critical services. In addition, long-term structural challenges persist within the payment system and with implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). These challenges include:

- **Regulatory Devaluation of Surgery:** Physicians were faced with a 2.5% cut to work Relative Value Units (RVUs) and intra-service time for all non-time-based codes in 2026, in addition to reductions in facility-based practice expense RVUs earned for procedures performed outside an office setting. These changes disproportionally affect surgical and other procedural specialties, put further strain on the surgical workforce, and threaten patient access to care.
- **Structural Limitations of the Physician Fee Schedule:** The MPFS remains the only Medicare payment system that is not indexed for inflation, and physicians have seen their reimbursement decline over the last several years while practice expenses such as rent, equipment, staffing, and utilities have increased. This challenge is compounded by overly strict budget neutrality requirements, which trigger across-the-board cuts when fee schedule changes increase spending by as little as $20 million annually.
- **Insufficient Quality Measures:** Most physicians in Medicare fee-for-service (FFS) are still evaluated based on measures that do not assess care delivered to their patients or the conditions they treat, meaning no information is available for improvement efforts or for patients and referring physicians to make care choices.
- **Lack of Alternative Payment Models:** Many surgeons wishing to move beyond FFS will find few physician-focused alternative payment models (APMs) are available for them. Current options are largely mandatory and some limit the ability of interested parties to opt-in. This is compounded by the failure to test voluntary, physician-directed models approved by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Congress can address recent misguided changes to physician reimbursement, as well as provide the Centers for Medicare & Medicaid Services (CMS) with direction, flexibility, and additional authority to help achieve the goal of improving value. The ACS proposes the following specific action items for Congress to consider:

- **Stop the 2.5% efficiency adjustment enacted in 2026 by passing the *Efficiency Adjustment Delay Act (H.R. 7520)* and address future pending cuts.**
- **Implement an update mechanism in the MPFS to account for inflation. This will create a stable base from which physicians can make the leap to value-based APMs.**
- **Eliminate the MPFS budget neutrality requirement or increase the trigger threshold and index it annually to account for inflation.**
- **Direct CMS to partner with stakeholders to test physician-developed APMs, such as those recommended previously by the PTAC.**
- **Create flexibility for shared measurement and accountability in the Merit-based Incentive Payment System, such as through expansion of facility-based scoring.**

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Health Subcommittee

of the

United States House of Representatives

"Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms"

May 20, 2026

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to you regarding the Subcommittee on Health hearing today on examining the Medicare Physician Fee Schedule, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and opportunities for payment reform. We remain committed to working with Congress on finding opportunities to stabilize the physician payment system and enhance the efficacy and participation in programs authorized by MACRA, as well as transition our health care system from volume to value.

The adoption of the bipartisan MACRA was an important step in shifting the physician payment model from fee-for-service payment to quality and value metrics-based reimbursements by replacing the historical Sustainable Growth Rate with the Quality Payment Program (QPP). The QPP consists of two tracks: the default Merit-based Incentive Payment System (MIPS) and a track for clinicians who exhibit sufficient levels of participation in certain Advanced Alternative Payment Models (APMs). As hospitals

and health systems continue to deal with unprecedented strain due to rising inflation, massive staffing shortages and a variety of other factors, it is more crucial than ever to provide the field with financial stability and further the transition to value-based care.

Over the past few years, the AHA has responded to a variety of Congressional requests for information regarding larger-scale reform to MACRA and the physician payment system. Below are highlights from our responses regarding legislative reforms that Congress should consider to further support flexible implementation and widespread participation in value-based and alternative payment models while delivering improvements in the cost and quality of care.

Physician Fee Schedule Updates

Conversion Factor Updates**.** Physician reimbursement updates have not accounted for rising inflation or increasing input costs (like supply chain disruptions and workforce shortages). The widening gap between physician reimbursement rates and increases in the Medicare Economic Index poses significant threats to patient access and provider financial stability, particularly for safety-net providers. The latest Medicare Trustees report acknowledged the inadequacy of Medicare physician payments and the potential impact on the quality of care. It states, "[c]ertain features of current law may result in some challenges for the Medicare program. For example, physician payment update amounts are specified for all future years. These amounts do not vary based on underlying economic conditions, and they are not expected to keep pace with the average rate of physician cost increases."[1]

Beginning in 2026, the current conversion factor updates established in MACRA will only result in a 0.75% conversion factor update for clinicians who are QPs and 0.25% for all other clinicians. Indeed, these annual updates are insufficient, considering physician payment has dropped by 33% since 2001 when accounting for inflation.[2] While the conversion factor updates provided in H.R. 1 have provided some needed relief for calendar year (CY) 2026 in the interim, we would encourage more sustainable, real-time approaches to updating the conversion factor in line with inflation. Annual conversion factor updates should be made to reflect changes in input costs and inflation. This will support physicians' ability to transition to APMs.

Merit-based Incentive Payment System

Improve Measures in MIPS Cost Category. The AHA believes that rigorously designed, clinically relevant cost measures can help provide insights into the value of care that clinicians deliver. At the same time, we have long been concerned with these measures' limited actionability, extraordinary complexity, questionable reliability and rushed implementation. The cost measures currently in place have flawed metrics in evaluating performance and may result in rewards or penalties based on differences in patient

[1] https://www.cms.gov/oact/tr/2025
[2] https://www.ama-assn.org/system/files/2026-medicare-updates-inflation-chart.pdf

population or statistical noise. Congress should encourage the Centers for Medicare & Medicaid Services (CMS) to take steps to improve these cost measures by pursuing consensus-based entity endorsement of all cost measures used in the MIPS; reexamining the attribution methodologies; and accounting for the influence of upstream risk factors beyond providers' control in calculating performance where necessary and appropriate.

Role of Alternative Payment Models in Value-based Care

Our members support the U.S. health care system progressing toward more outcomes-based, coordinated care, and they continue to redesign delivery systems to increase value and better serve patients. The AHA appreciates CMS' continued efforts to develop innovative payment models to reward providers based on outcomes rather than patient volume.

Over the last 15 years, many of our hospital and health system members have participated in a variety of APMs developed by the Center for Medicare & Medicaid Innovation (CMMI). Some APMs have generated net savings for taxpayers while maintaining the quality of care for patients.

While the movement to value holds tremendous promise, the transition has been slower than anticipated, and more needs to be done to drive long-term system transformations. CMMI plays a critical role in ensuring that hospitals and providers are set up for success in the various models they deploy. But some of the CMMI models were designed with requirements that made implementation exceedingly difficult and success even more so.

There are principles that we have previously recommended Congress and CMMI consider to guide the development of APM design. These include:

Appropriate On-ramp and Glidepath to Risk. Model participants should have an adequate on-ramp and glidepath to transition to risk. They must have adequate time to implement care delivery changes (integrating new staff, changing clinical workflows, implementing new analytics tools, etc.) and review data prior to initiating the program.

Adequate Risk Adjustment. Models should include adequate risk adjustment methodologies to account for social needs and clinical complexity. This would ensure models do not inappropriately penalize participants who treat the sickest, most complicated and underserved patients.

Voluntary Participation and Flexible Design. Model designs should be flexible, incorporating features such as voluntary participation, the ability to choose individual clinical episodes, the ability to add components and/or waivers, and options for participants to leave the models.

Balanced Risk Versus Reward. Models should also balance the risk versus reward in a way that encourages providers to take on additional risk without penalizing those who need time and experience before they can do so. A glidepath approach should be implemented, gradually migrating from upside-only to downside risk.

Guardrails to Ensure Hospitals Do Not Compete Against Their Own Best Performance. Models should provide guardrails to ensure that participants are not penalized over time when they achieve optimal cost savings and outcomes performance. Participants must have incentives to remain in models for the long term.

Resources to Support Initial Investment. To be successful in their transition to value-based payment models, hospitals, health systems and provider groups must invest in additional staffing and infrastructure to support care delivery redesign and outcomes tracking. Therefore, upfront investment incentives should be provided to support organizations.

Transparency. Models' methodologies, data and design elements should be shared transparently with all potential participants. Proposed changes should be vetted with stakeholders.

Adequate Model Duration. Models should remain in place long enough to truly support care delivery transformation and assess the impact on outcomes. Historically, models were too short and/or had multiple, significant design changes even within the designated duration, making it difficult for participants to self-evaluate and change course when necessary.

Timely Availability of Data. Model participants should have readily available, timely access to data about their patient populations. Ideally, CMS would dedicate staff and technology to help provide program participants with more complete data as close to real-time as possible.

Waivers to Address Barriers to Clinical Integration and Care Coordination. Models must include waivers of statutory provisions and Medicare program regulations that inhibit care coordination and work against participants' efforts to ensure that care is provided in the right place at the right time.

To ensure that these and other practical considerations are appropriately included in CMMI models, we believe the agency would benefit enormously from a periodic required consultation with an advisory group of hospital and health system leaders who are managing or have managed the kind of organizations that would be part of the models CMS is trying to build.

Advanced APMs

Extension of Advanced APM Incentive Payments and Qualifying Thresholds. We appreciate Congress acting through a provision in the Consolidated Appropriations Act

of 2026 to extend the Advanced APM incentive payments at 3.1% for the CY 2026 payment year and maintain the current thresholds for clinicians to achieve qualifying APM participant (QP) status. While lower than the 5% incentive payment rate established by MACRA, the incentive provides crucial resources to support non-fee-for-service programs, including meal delivery programs, transportation services, digital tools and care coordinators, each of which promotes population health. Because participation in Advanced APMs has fallen short of initial projections, spending on the incentives has fallen well short of the amount the Congressional Budget Office projected when MACRA was originally scored. Repurposing the spending shortfall for APM incentive payments in future years, as well as maintaining the current thresholds for QP status, will accelerate our shared goal of increasing Advanced APM participation.

Support Investment in Resources for Rural Hospitals. Congress should encourage CMS to continue investing resources and infrastructure to support rural hospitals' transition to APMs. According to a Government Accountability Office report, only 12% of eligible rural providers participated in Advanced APMs in 2019; of those that participated, just 6% of rural providers participated in two or more Advanced APMs, compared to 11% of those not in rural areas.[3] These models are often not designed in ways that allow broad rural participation, and the AHA supports continued efforts to better support rural hospitals' migration to Advanced APMs. In particular, the AHA, since 2021, has supported the establishment of a Rural Design Center within CMMI, which would focus on smaller-scale initiatives to meet rural communities' needs and encourage participation from rural hospitals and facility types. A Rural Design Center would help develop and increase the number of new rural-focused CMMI models, expand existing rural demonstrations and create separate rural tracks within new or existing CMMI models.

Accountable Care Organizations

Promote Gradual Transition to Performance-based Risk. We support the gradual transition to performance-based risk for certain Accountable Care Organizations (ACOs). For example, allowing ACOs inexperienced with performance-based risk to participate in one-sided shared savings models for a limited or indefinite duration will provide more time for ACOs to invest in necessary infrastructure and adjust workflows. More gradual glidepaths to risk will help increase participation, experience and shared savings by empowering ACOs to maximize their contribution to patient care.

Eliminate Low-revenue/High-revenue Qualifying Criteria. Congress also should require CMS to eliminate its designation of ACOs as either low- or high-revenue. The agency has used this label as a proxy measure to, for example, determine if an organization supports underserved populations by ascertaining whether the organization is physician-led (low-revenue) or hospital-led (high-revenue). The agency has then limited

[3] U.S. Government Accountability Office (November 2021). "Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas." https://www.gao.gov/assets/gao-22-104618.pdf

participation in certain APMs or qualification for advance investment payments (AIPs) to only physician-led or low-revenue ACOs. Yet, there is no evidence to conclude that this delineation, which measures an ACO's amount of "captured" revenue, is an accurate or appropriate predictor of whether it treats an underserved region.

High-revenue ACOs often have more clinically complex, higher-cost patients attributed to them. In addition, limiting eligibility for AIPs to only low-revenue ACOs inappropriately penalizes high-revenue ACOs, many of which actually are small organizations that need these critical resources for infrastructure investment to transition to APMs. In fact, analysis suggests that critical access hospitals, federally qualified health centers and rural health clinics are predominantly classified as high-revenue and therefore ineligible for AIPs. This partially explains the disparity in APM adoption in rural and underserved areas; assistance in investing in these efforts would help across the board.

Conclusion

The AHA appreciates the Energy and Commerce Health Subcommittee recognizing the need for large scale reform to further the transition to value-based care. We look forward to working with you on ways to support greater participation and enhanced efficacy of MACRA on behalf of our patients and their communities.

Alliance of Specialty Medicine

Sound Policy. Quality Care.

May 20, 2026

The Honorable Brett Guthrie
Chair
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
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The Honorable Morgan Griffith
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RE: Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms

Dear Chairs Guthrie and Griffith, and Ranking Members Pallone and DeGette,

The Alliance of Specialty Medicine (Alliance) thanks the House Energy and Commerce Subcommittee on Health for holding a hearing on such an important topic. We write to share our ideas about Medicare physician payment reform and opportunities to better measure and reward high value care among physicians. The Alliance, which represents 15 specialty organizations and more than 100,000 physicians, is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. The Alliance greatly appreciates your proactive engagement and willingness to collaborate with us and other stakeholders.

Below we share our recommendations on legislative reforms to improve the Medicare physician payment system, the Quality Payment Program (QPP), and the Center for Medicare and Medicaid Innovation (CMMI).

Medicare Physician Payment Reform (MPFS)

Prior to the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), the costs associated with running a physician practice were on the rise. We continue to see substantial increases in prices for medical supplies, equipment, and clinical and administrative labor, as demonstrated by the Consumer Price Index (CPI) and the Medicare Economic Index (MEI).[1] MACRA established physician payment updates without a yearly automatic inflation adjustment unlike other Medicare providers, which receive annual payment updates based on an inflation proxy, such as the CPI. Given the lack of an automatic payment update, when adjusted for

[1] https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf

inflation in practice costs, Medicare physician payments declined 33% from 2001 to 2025.[2] While Congress anticipated that physicians would receive value-based incentives and differential payment updates based on their participation in either the Merit-based Incentive Payment System (MIPS) or alternative payment model (APM) tracks, many factors have led to insufficient payment updates, particularly when compared to the effort and resources physicians must devote to participate.

The Medicare Trustees[3] and other policy experts have raised concerns about the lack of an inflation measure in the Medicare physician fee schedule (MPFS). According to the Medicare Payment Advisory Commission (MedPAC), this downward financial pressure on physicians has forced many to sell their practices to health systems and private equity groups and enter into employment arrangements with these entities, further consolidating health care systems and increasing health care costs to taxpayers and beneficiaries.[4] Research by the American Medical Association (AMA) found that 42.2% of physicians remained in private practice as of 2024, but many are selling their practices because inadequate payment rates, soaring resource costs, and overwhelming regulatory and administrative burdens make independence increasingly unsustainable.[5]

Beyond the challenges in physician payment created under MACRA, the MPFS is plagued by other challenges, including requirements to maintain budget neutrality and irregularly timed updates to practice expense data used to set payments. In fact, physicians absorbed substantial budget neutrality adjustment prompted by the Centers for Medicare and Medicaid Services' (CMS') 2021 and 2023 implementation of increased relative values for office and outpatient evaluation and management (E/M) services and inpatient and other E/M services, respectively, as well as CMS' 2022 implementation of revised clinical labor prices (an update that lagged two decades). While these adjustments were implemented prospectively, the resulting reductions permanently lowered the MPFS conversion factor baseline. Compounding the issue, CMS relies on prospective utilization assumptions when estimating the budget neutrality impact of newly payable services. However, when those projections overestimate actual utilization, which occurred with Transitional Care Management (TCM) services and the complex care add-on code (HCPCS G2211), the resulting reductions to the MPFS conversion factor (CF) are not subsequently restored.

We appreciate congressional efforts to reduce CF cuts temporarily; however, Congress has still allowed year after year of cuts to the MPFS CF, and this pattern is unsustainable. The 2026 MPFS CF equals $33.40 for non-qualifying APM participants (or $33.57 for qualifying APM participants). In 2016, it was almost $36.00.

The Alliance recognizes that Congress provided a 2.5% increase to the Medicare conversion factor in 2026, but calls on Congress to simultaneously embrace long term reforms to **prevent recurring annual Medicare cuts** and **enact permanent solutions to stabilize Medicare physician payments, support investments in value-based care, and improve the quality of care provided to Medicare beneficiaries.**

Requested Legislative Reforms to the MPFS

The Alliance urges Congress to:

- Provide a permanent, inflation-based update equal to MEI, without reductions or caps.
- Modernize and update the budget neutrality mechanism by increasing the threshold to $54.3 million and indexing it to MEI every five years, requiring that direct cost calculations and valuations be updated every five years in consultation with relevant stakeholders, and limiting year-to-year variance of the conversion factor to 2.5%.

[2] https://fixmedicarenow.org/sites/default/files/2025-01/Medicare Gap Chart_2025.pdf
[3] https://www.cms.gov/oact/tr/2025
[4] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf
[5] https://www.ama-assn.org/practice-management/private-practices/smaller-share-doctors-private-practice-ever

Merit-Based Incentive Payment System (MIPS)

Implementation of MACRA's two-track value-based payment system, the QPP, has been ineffective and, arguably, detrimental to the delivery of most specialty medical care. Many specialists perceive MIPS, in particular, as an enormous administrative hassle that simply diverts critical resources away from more meaningful activities that could directly improve the quality and value of specialty care. Often under MIPS, specialty physicians have no other choice but to report on marginally relevant measures that result in data that is of little use to physicians or their patients. Further, CMS has not produced any evidence to date to suggest that quality, efficiency and outcomes for Medicare's seniors, the disabled, and underserved populations have demonstrably improved as a result of the MACRA-established quality programs.

In contrast to the promises of MACRA, MIPS has evolved into an overly complex, disjointed, burdensome, and clinically irrelevant program for many specialists. Even the Government Accountability Office (GAO), in an October 2021 report,[6] expressed concern that MIPS performance feedback is neither timely nor meaningful, questioned whether the program helps improve quality and patient outcomes, and highlighted the program's low return on investment. In its March 2024 environmental scan of value-based payment models,[7] the Physician-Focused Payment Model Technical Advisory Committee (PTAC) noted: "Overall, there is little evidence that pay-for-performance and public reporting of quality measures have improved overall quality of care in the United States."

The Alliance requests that the Committee consider the following fundamental flaws that continue to plague MIPS:

- **Siloed Performance Categories**. CMS has failed to produce a more unified quality reporting structure, as promised under MACRA. MIPS continues to rely on four separate performance categories that each have distinct and complex reporting requirements and scoring rules, making program compliance extremely resource intensive with little to no evidence of value. Additionally, for many specialties, what is being measured on the quality side rarely aligns with what is being measured on the cost side, resulting in a flawed value equation. The Alliance has repeatedly asked CMS to provide cross-category credit for more comprehensive value-based activities, such as reporting and regularly tracking performance through a clinical data registry, which would minimize duplicative and misguided reporting mandates while rewarding more meaningful investments in value-based care. However, CMS continues to cite statutory constraints, including the mandate to measure clinicians on each of the four MIPS performance categories as dictated by MACRA. As a result, the program is not only challenging to navigate and comply with, but for many specialties, it does not meaningfully reflect the overall value of care.
- **Constantly Shifting Goalposts**. Each year, CMS changes MIPS participation rules, including rules around eligibility, reporting requirements, and available measures. CMS also has the authority to update performance thresholds, which the agency has done many times since the program launched. As a result, it is challenging for physicians to keep up with the program and to make year-to-year comparisons regarding their performance. It is equally challenging for CMS to analyze the overall impact of the program over time accurately.
- **Lack of Incentives for Specialty Measures**. Many specialties have also faced challenges getting more specialty-focused quality measures approved for the program due to excessively burdensome and costly measure testing and maintenance requirements, including those that apply to Qualified Clinical Data Registries (QCDR). QCDRs, in particular, were authorized by Congress to provide a more flexible and rapid pathway for specialties to introduce more innovative and clinically relevant measures under MIPS. Instead, many prominent specialty-sponsored registries have had no other choice but to leave the program. This is unfortunate since clinician-led registries tend to collect more relevant and robust clinical outcomes data, including patient-reported outcomes data, that cannot be captured through claims. They also provide more timely and actionable feedback that is often more meaningful to participating

[6] https://www.gao.gov/assets/gao-22-104667.pdf
[7] https://aspe.hhs.gov/sites/default/files/documents/dae3de25b874112a649445d6381f527e/PTAC-Mar-25-Escan.pdf

clinicians and their patient populations than what is provided by CMS under MIPS. And even when specialty-focused measures are approved for MIPS, our organizations still face challenges getting members to report the measures due to MIPS scoring policies that disincentivize the use of such measures— especially measures such as patient-reported outcomes measures, which are more time-consuming to collect, but more meaningful to patients and physicians.

- **Barriers to Accessing Claims Data.** Specialty societies and QCDRs have also faced major challenges in accessing claims data. Claims data acquisition is costly and time-consuming, and specialty societies continue to face delays in trying to access such data. Specialty societies are willing to assist CMS with more robust quality and cost analyses but cannot do this without reasonable access to timely Medicare claims data.
- **Flawed Cost Measures**. Cost measures adopted for MIPS are also extremely difficult to interpret and take meaningful action on, and efforts to implement cost measures under MIPS to date have uncovered a variety of complex issues that make physician-level accountability an ongoing challenge. They often reflect care decisions and costs that are outside of an individual physician's direct control and rarely align directly with quality measures other than in the title. While Total Cost measures are the most problematic, even more focused episode-based cost measures often hold physicians responsible for costs that they cannot control. For example, autoimmune diseases such as rheumatoid arthritis and Crohn's disease are managed with highly complex medications, including biologics, that physicians have little control over. Depending on the patient's unique biology, disease progression, and other clinical factors, one therapy may be clinically indicated, recommended and prescribed over another. Additionally, MIPS cost measures to date have measured cost of care *in isolation*, failing to account for the impact that changes in spending have on care quality and access to care. This is even true under CMS' new MIPS Value Pathways (MVP) Framework, which was intended to align performance assessment across the four MIPS performance categories. Unfortunately, MVPs too often include a cost measure addressing a specific condition, but no corresponding quality measure that addresses the same condition/ population. Therefore, it is not clear if the MIPS participant achieved good cost performance by improving value, or by simply holding back on appropriate care.
- **Lack of Flexibility to Promote Interoperability**. The MIPS Promoting Interoperability category continues to take a one-size-fits-all approach to care that fails to appreciate the diversity and readiness of practices across the nation. The category also continues to focus on very specific EHR functionalities rather than promoting innovative use cases of health information technology, such as clinical data registries, clinical decision support tools, and tracking data from wearables and other digital devices that are more common among specialty patients. EHR adoption and federal policies supporting interoperability have advanced significantly since the enactment of MACRA. There is much more widespread use of CEHRT among clinicians, and CEHRT requirements have evolved to a point where users of CEHRT are inherently satisfying the actions that the current set of MIPS Promoting Interoperability measures originally set out to capture and incentivize (e.g., secure data exchange). Where they are not, it is not the fault of the clinician, but the EHR vendor or institution deploying the technology. As a result, this category of MIPS has become outdated and should be revised to better represent the current landscape and minimize unnecessary reporting burden.
- **Failure to Provide a Glidepath to APM Participation**. The intent of MIPS, as envisioned by MACRA, was to prepare physicians to move into APMs. However, the current program — even as revised through the MVP Framework — largely fails to align with measures used under APMs and does little to ready specialists to move into APMs. Further, there are ongoing barriers to APM participation among specialists, as explained earlier.
- **Misguided Efforts to Improve MIPS**. Although CMS' MVP Framework was intended to address many of the problems outlined above, it simply reshuffles the deck while doing very little to address the program's foundational flaws, which increases frustration and disillusionment among physicians at a time when physician burnout is at an historical high. Compounding these concerns, CMS recently finalized a new mandatory APM – the Ambulatory Specialty Model (or ASM) – which builds directly on the MVP framework, despite widespread concern among specialties that MVPs do little to address the

shortcomings of traditional MIPS. As noted in our comments to CMS[8], the Alliance believes the model further exacerbates existing flaws in MIPS rather than creating a true path forward for specialists to engage meaningfully in value-based care. For these reasons, the Alliance strongly urges Congress to prohibit CMS from implementing the Ambulatory Specialty Model. Instead, CMS should work collaboratively with specialty societies to design models that are grounded in clinically meaningful measures, structured to incentivize rather than mandate participation, and aligned with a pathway to Advanced APM participation.

Requested Legislative Reforms Related to MIPS

The Alliance urges Congress to:

- Give CMS the authority to move beyond the four siloed performance categories of MIPS and instead recognize more comprehensive and innovative investments in high value care.
- Better recognize the value of clinical data registries and their role in the QPP by, for example, allowing clinicians to receive credit across all four MIPS categories for registry participation that meets minimum standards and recognizing similar participation pathways that are more meaningful to specialists.
- Require CMS to better incentivize the development and use of specialty-focused metrics through technical assistance, less resource-intensive measure testing policies, and revised MIPS scoring policies that promote the reporting of such measures.
- Allow physicians to meet Promoting Interoperability requirements via "yes/no" attestation of using Certified Electronic Health Record Technology (CEHRT) or technology that interacts with CEHRT, such as participation in a clinical data registry. Since MACRA was first signed into law, the Office of the National Coordinator for Health Information Technology (ONC), in collaboration with CMS, has finalized numerous regulations intended to better support the electronic exchange of data, incentivize the use of technology, and promote interoperability. In the most recently issued HTI-5 proposed rule,[9] ONC even proposes to significantly streamline requirements imposed on EHR vendors under the Health Information Technology Certification Program, acknowledging that efforts to incentivize interoperability have evolved and that many program requirements are now either obsolete or have become market baseline. Requirements imposed on clinicians should similarly recognize the maturity of EHR adoption and aim to minimize reporting burden. The majority of impediments to further progress in this space are not in the direct control of physicians, but rather EHR vendors and the facilities or health systems in which physicians practice.
- Allow CMS to modify the MIPS Cost category by:
    - Removing the primary care-based total per capita costs measure mandate in MACRA that continues to hold physicians — including specialties that are explicitly excluded from the measure — responsible for costs outside of their control.
    - Removing the MACRA requirement that episode-based cost measures account for at least half of Part A and B expenditures to ensure prioritization of episodes with high variability and that specialists can directly impact.
    - Requiring that any evaluation of cost also simultaneously accounts for any changes in quality indicators meaningfully tied to cost performance, including within the same patient population, to ensure cost-containment efforts do not result in poorer quality care or negatively impacts access to care (i.e., true measures of value).
- Enforce MACRA's requirement that CMS provide access to Medicare claims data to assist specialties and their registries with a better understanding of existing gaps in care and support the development of quality and cost measures.
- Require CMS to release more granular and timely data regarding physician participation in MIPS.

[8] https://specialtydocs.org/wp-content/uploads/2025/09/Alliance_CY-2026-MPFS-Comments_FINAL-submitted.pdf
[9] 90 FR 60970

The Center for Medicare and Medicaid Innovation (CMMI) and Alternative Payment Models (APMs)

CMS has released very little specialty-specific APM data to date, making it challenging to fully understand the availability and impact of these models on specialists, as well as barriers to engagement. While CMS' annual QPP Experience Report[10] and associated QPP Public Use Files (PUF)[11] include comprehensive participation and performance data related to the MIPS, it only includes aggregate national data on the total number of clinicians that were QPs in an Advanced APM. It does not provide any detailed breakdown of QP status or APM participation by specialty or by practice type (e.g., small practice, rural, facility-based, etc.).

In addition, most specialty physicians have struggled to meaningfully engage in the Advanced APM track of the QPP, as there are only a few APMs that are applicable to specialty care and meet the Advanced APM criteria. Through discussions with Alliance member organizations and the physicians they represent, we have found that accountable care organizations (ACOs) are often the only option for APM engagement. However, the decision to participate in an ACO is often made by a specialist's hospital or health system, or a result of healthcare consolidation, and the specialist's role in the model is often passive. Additionally, specialists do not have an opportunity to meaningfully engage in quality improvement or cost containment activities specific to their patient population since ACO measures do not reflect the conditions they treat or the services they provide.

As a result, active and meaningful engagement in APMs is nearly impossible. Previously tested specialty-focused APMs (e.g., the Bundled Payments for Care Improvement–Advanced (BPCI-A)) have only targeted a limited number of conditions or procedures and failed to provide high-performing practices with an incentive to stay in the model due to exceedingly challenging spending targets that simply do not support high quality, appropriate care. More recently announced models, such as the Ambulatory Specialty Model (ASM), are mandatory and were developed without specialty society input. As a result, specialists are increasingly being forced to participate in models that rely on misguided measures and methodologies.

The Alliance appreciates CMMI's recent recognition that a comprehensive approach to accountable care must account for both primary care and specialty care and that it is exploring opportunities to build on the "shadow bundle" concept where specific episode-based or condition-specific models are nested in population-based total cost of care (PB-TCOC) models. However, we are concerned that these initiatives are being rolled out without broader specialty engagement or input and may offer limited opportunities for meaningful specialist involvement. Some Alliance member organizations have already invested in this type of work, yet they continue to face challenges in terms of getting CMS to adopt these models.

The Alliance is disappointed with the ongoing lack of models and relevant participation pathways for specialists. We are also frustrated by the limited opportunities that specialists have had to date to become Qualifying Participants (QPs) in Advanced APMs under the QPP. As a reminder, under current law, the QP thresholds are scheduled to increase and the APM incentive is scheduled to end starting with the 2027 performance year/2029 payment year, as reflected below:

QP Thresholds

- 2022/2024: 50% Part B Payments/ 35% Part B Patients
- 2023/2025: 50% Part B Payments/ 35% Part B Patients
- 2024/2026: 50% Part B Payments/ 35% Part B Patients
- 2025/2027: 75% Part B Payments/ 50% Part B Patients
- 2026/2028: 50% Part B Payments/ 35% Part B Patients
- 2027/2029: 75% Part B Payments/ 50% Part B Patients

[10] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3269/2023-QPP-Experience-Report.pdf
[11] https://qpp.cms.gov/resources/performance-data

APM Incentive Payment

- 2022/2024: 5%
- 2023/2025: 3.5%
- 2024/2026: 1.88% (+ differential CF update for QPs (0.75%) vs. non-QPs (0.25%))
- 2025/2027: No incentive payment; just differential CF update
- 2026/2028: 3.1% (+ differential CF update)
- 2027/2029: No incentive payment; just differential CF update

The Alliance very much appreciates that Congress has acted multiple times to freeze the QP threshold and extend the APM incentive payment. However, without a further extension of these provisions, many specialists will never have had an opportunity to benefit from the APM incentive payment, which allows physicians to invest in the infrastructure and analytics needed to engage successfully in such models and provide higher value care. These shifts in policy contradict the Congressional intent of MACRA, which was to encourage clinician movement into APMs, using MIPS as a springboard, not as a long-term solution. Unfortunately, these changes also come at time when we are finally starting to see measurable progress in terms of the number of clinicians moving into Advanced APMs. The 2024 performance year was the first time since the enactment of MACRA that the number of QPs exceeded the number of MIPS eligible clinicians. Although we do not know what proportion of QPs have been specialists, without additional Congressional action, we expect to see a reversal in this progress and potentially a situation where MIPS incentive payments begin to exceed APM incentive payments, causing movement away from APMs, contrary to Congress' vision.

Requested Legislative Reforms Related to the CMMI and APMs

The Alliance urges Congress to:

- Require CMS to release more granular and timely data regarding specialty participation in CMMI-tested models and other CMS alternative payment models (APMs); the impact of those models on quality, value, and access to specialty care; and eligibility for the Advanced APM track of the QPP by specialty.
    - As a starting point, Congress should direct GAO to conduct a study on APMs that documents gaps in current availability of APMs for specialists, identifies current barriers to specialist participation in APMs, collects insights from specialists and other physicians on how they would like to see APMs designed, and evaluates more specifically the reasons why specialty-focused models have not moved forward.
- Require CMMI to employ more transparent processes when developing and evaluating models. Specifically, CMMI should be required to consult with potentially impacted stakeholders prior to implementing a model and be required to publish a notice of model concepts early in the model development phase. This would promote greater transparency in model design and ensure all stakeholders have an opportunity to meaningfully engage with CMMI on the development of models. Similarly, CMMI should be required to publicly explain why adopted models are terminated early or not expanded to identify lessons learned in order to inform future models. CMMI should be held accountable to Congress and the public in a manner that builds trust in these processes, but is not so cumbersome as to stifle progress and innovation.
- Congress should also require CMMI to work collaboratively with specialty societies to improve the APM pipeline. This could include requiring CMMI to technical assistance and more specific guidance to specialists and their societies on how to get APMs approved for testing. Specialty societies have invested significantly in the development of models that have been repeatedly rejected or ignored.
- For population-based models that have been more geared toward primary care, such as ACOs, provide model entities with technical assistance that would allow them to appropriately analyze clinical and administrative data, improving their understanding of the role specialists play in addressing complex health conditions, such as preventing acute exacerbations of comorbid conditions associated with chronic disease.

- Extend opportunities for specialists to meet the eligibility criteria to become a QP in an Advanced APM under the QPP. Restore and extend the full 5% APM incentive payment, as well as the lower QP thresholds to facilitate specialty physician movement into Advanced APMs, including new and more relevant models that have not yet materialized.
- Terminate the deeply flawed Ambulatory Specialty Model (ASM) recently finalized by CMS.

Thank you for your ongoing leadership in addressing Medicare physician payment and quality programs. We welcome the opportunity to work with you on these important issues. If you have any questions, please do not hesitate to contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists
Society of Interventional Radiology

U.S. House Energy and Commerce Health Subcommittee

Hearing: “Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms”

May 19, 2026

Statement for the Record by the American Physical Therapy Association

3030 Potomac Ave., Suite 100 / Alexandria, VA 22305-3085 / 703-684-2782 / apta.org

Chairman Griffith, Ranking Member DeGette, and Members of the U.S. House Energy and Commerce Health Subcommittee:

On behalf of the approximately 100,000-member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments in response to the Subcommittee's hearing, *"Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms."* APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

"The Economic Value of Physical Therapy in the United States," a recently released APTA report, showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. The report compares physical therapy with alternative care across a suite of health conditions commonly seen within the U.S. health care system. The report underscores the importance of including physical therapists and physical therapist assistants in multidisciplinary teams focused on improving patient outcomes and reducing downstream costs. The committee should consider the insights provided in this report to support access to, coverage of, and payment for physical therapist services in rural and underserved areas, and to support policies that position physical therapists as entry-point providers, ensuring beneficiaries have timely access to proven, cost-effective care, as outlined in our recommendations below.

Background

The 2015 Medicare Access and CHIP Reauthorization Act, known as MACRA, replaced the flawed Sustainable Growth Rate formula with the Quality Payment Program, or QPP. The QPP comprises two tracks: the Merit-based Incentive Payment System, or MIPS, and Advanced Alternative Payment Models, also known as AAPMs. The Centers for Medicare & Medicaid Services (CMS) began implementing the QPP in 2017, with the eventual goal of moving providers out of MIPS and into AAPMs. **There are several foundational**

issues with MACRA and the QPP that disproportionately affect nonphysician-qualified health care providers, such as physical therapists. In addition, there are logistical and operational barriers to therapists participating in MIPS and AAPMs. Some of the current challenges facing therapy providers include:

- **MACRA Has Not Stabilized Payment Under the Medicare Physician Fee Schedule**. MACRA sought to stabilize payments by repealing the Sustainable Growth Rate formula and providing payment adjustments under the QPP. Despite that goal, these changes replaced relief from the growth rate cuts with payment cuts to the conversion factor; as a result, budget neutrality requirements limit the effectiveness of payment incentives provided under MIPS and have required annual legislative intervention to stave off untenable payment cuts. Further, nonphysician providers, including therapists, have few options under the QPP to receive payment adjustments that would otherwise offset payment cuts. **In 2021, the average payment per therapy claim *was the same as it was in 2010*.** Since 2025, therapy services have been further cut due to reductions in the conversion factor. An additional 15% cut to services provided by physical therapist assistants was implemented in 2023. This decrease in payment is simply not sustainable if we are to have a robust workforce that supports access to rehabilitation therapy services nationwide. Providers are suffering from a workforce shortage, and MACRA policies are reducing the resources needed for adequate therapists to meet patient access needs.

- **QPP Does Not Promote Value-Based Care or Effectively Measure Quality of Care**. The QPP does not allow for adequate participation for therapists in either MIPS or AAPMs. The lack of appropriate quality metrics and the failure to include all outpatient therapy providers in MIPS and AAPMs have prevented the shift to value-based care. These problems are compounded by slow, ineffective mechanisms for innovation within the QPP. This means physical therapists who were not fully considered in the QPP's design still cannot meaningfully participate.

- **MIPS Rewards Participation Rather Than Performance.** Because MIPS was created as a budget-neutral program, there is no avenue for all providers to achieve meaningful bonuses, regardless of performance. Payment adjustments in MIPS have been, and remain, deceptively low. In theory, payment adjustments achieved through MIPS were +/- 9% in 2023, the most recent year of available data. The opportunity, however, to earn up to a 9% payment increase (or any high-end increase) is effectively a mirage within this budget-neutral system. The overwhelming majority of

participating MIPS providers receive a positive adjustment (80.86% in 2023), thereby reducing the opportunity for any individual provider to earn high-end bonuses. The highest bonus ever earned under MIPS for a perfect score is still only slightly more than 2%, meaning there is realistically no avenue to achieve meaningful bonuses under MIPS for all providers, and this is even more acute for nonphysicians.

- **Barriers to Therapist Participation in MIPS.** Most physical therapists are not required to participate in MIPS, but are encouraged to opt in to the program. However, extremely limited payment incentives dissuade optional participation, as the cost of compliance outweighs even the highest historical incentives earned under the programs. With a limited PT/OT specialty measurement set and only one therapy cost measure, therapists have few reasons to participate under the program and suffer compounding pay cuts under the MPFS without any opportunity for mitigation through the QPP.

- **CEHRT is a Threshold Barrier for Therapists in MIPS and AAPMs.** Promoting interoperability through Certified Electronic Health Record Technology, or CEHRT, was part of MACRA's original vision. AAPMs promote this by requiring CEHRT as a prerequisite for AAPM opportunities, and, under MIPS, providers are scored on the "promoting interoperability" measure category. CEHRT options are simply not available to physical therapists, as their requirements are costly and burdensome, and many are specific only to physicians. As a result, physical therapists cannot participate in AAPMs and will receive a score of zero under MIPS in the interoperability category. Without vendors working to develop CEHRT for therapists (in part because there are not enough potential users to justify vendors' expense of CEHRT development), these providers will never be able to participate meaningfully. Requirements must be relaxed or modified; otherwise, physical therapists will continue to be assessed on an uneven playing field.

- **Barriers to Participation in AAPMs**. In addition to CEHRT as a threshold barrier to participation, the Qualifying Participant, or QP, threshold to earn incentives under the program, is also not realistically achievable for physical therapists. Further, while there is a Partial QP designation, it does not offer any incentives to participate and serves more to prepare clinicians who believe they would meet the QP threshold in the future. AAPMs could have therapist-specific thresholds or offer incentives for partial QPs to incentivize participation by therapists.

- **Inability of Facility-based Outpatient Therapy Providers to Participate in Bonus Payment Structures.** While outpatient private practice therapy services are paid

under the MPFS, services provided in facility-based settings, such as hospital outpatient departments, rehabilitation agencies, and skilled nursing facilities, are not considered to be a part of the MPFS. Rather, the 1997 Balanced Budget Act required that payments for facility-based outpatient therapy services be "based on" the value of those services as set forth in the MPFS. While therapy services provided under the fee schedule are billed through an individual's National Provider Identifier, all facility-based outpatient therapy services are billed through the facility, and not the individual therapist. This distinction is not insignificant. According to MedPAC, 63% of all Medicare outpatient therapy services are provided in facility-based settings, yet facility-based outpatient therapy providers have had no way to receive payment updates or bonus payments. However, these services are subject to budget neutrality cuts and any other policy affecting therapy payments through the physician fee schedule – such as the multiple procedure payment reduction, also known as MPPR, and cuts to services provided by physical therapist assistants.

Recommendations to Reform MACRA to Allow Broader Participation by Therapy Providers:

Within MACRA, the QPP has posed significant challenges to nonphysician providers. Physical therapists, in particular, have struggled to meaningfully participate in MIPS or engage in AAPMs, in part because CMS has failed to pilot or implement several alternative payment and delivery models applicable to therapy providers. Congress must enact meaningful reforms to the QPP that specifically recognize the value of therapy providers and allow them to provide effective oversight of the QPP to determine its effectiveness at measuring therapy performance and outcomes.

The value of any quality program depends on the ability of all providers to participate. Given the complex and unique challenges faced by physical therapists under QPP, including limited opportunities for therapists' participation in the program, APTA offers the following recommendations to Congress to improve the QPP:

- **Congress Should Authorize a Therapy QPP Reform Workgroup.** As part of any reforms to QPP, Congress should authorize a therapy stakeholder workgroup under the Department of Health & Human Services, comprised of representatives of nonphysician therapy providers (PT, OT, SLP), to identify barriers specific to therapy providers and develop specific recommendations for the Secretary of the Department of Health and Human Services to adopt via rulemaking. APTA has

drafted proposed legislative language that would implement this recommendation; please see Appendix A.

- **Make MIPS Participation Voluntary for Physical Therapists until Meaningful Changes are Made.** There is no immediate path to meaningful participation for all physical therapists without foundational and timely modifications to the cost measure development process and the PT/OT measure set. Currently, physical therapists have only one cost measure available to them, and it applies to fewer than 50% of them. For now, we ask CMS to consider a more equitable approach for physical therapists: to make participation voluntary until additional cost and quality measures are developed and included in the program. There is, simply put, no equitable way forward under the current system, and the authorizing statute for the MACRA does not require PT participation in the program. Until measures appropriately distinguish between high-value and low-value care, financial support is provided for the integration of CEHRT, the contribution of PTs to patients' outcomes is accounted for, and PTs should not be expected to participate in the program. At this point, physical therapists only view the QPP as an obligation with practically no upside. It is an administrative burden that is not designed or currently capable of measuring physical therapists' actual impact on patients. Until more financial and structural investments are made to ensure nonphysicians can be accurately assessed and measured by the QPP, most will seek any means to be exempt from the program.

- **Advance Value-Based Care Models that Recognize the Value of Physical Therapist Services.** Effective quality programs engage numerous health care providers, not just physicians. To demonstrate the ability of non-physician providers to engage in and even lead value-based care, **APTA has created an Alternative Payment Model that addresses frailty by incorporating physical therapists into a patient's primary care team.** In the model, potential patients are screened for frailty, and those identified as frail or pre-fail receive a functional assessment by a physical therapist, including the Short Physical Performance Battery and the PROMIS Physical Function SF 10a. The combination of these assessments provides a functional profile of the individual as well as a risk assessment for adverse events, including falls, ED visits, hospitalizations, morbidity, and mortality. Once a functional baseline is established, a plan is developed and implemented in collaboration with the individual and any involved caregivers. This plan may include referral for skilled physical therapy. Alternatively, or concurrently, the plan addresses safety issues and

connects the individual with evidence-based programs in the home, virtually, and/or in the community. The tests are readministered at 30 days, 60 days, 90 days, and 180 days, and then annually to track the individual's status and modify the program as needed. Key to the success of the model is the use of a physical therapist to address the physical and functional components of frailty. As Congress evaluates the future of value-based care, APTA urges Congress to consider the frailty of APM and other models that employ non-physician providers.

Other Recommendations to Reform the Medicare Physician Fee Schedule:

- **Eliminate the Multiple Procedure Payment Reduction Policy**. The MPPR Policy, first implemented in 2011, applies to physical therapy, occupational therapy, and speech-language pathology services provided under Medicare Part B. Because of MPPR, when therapists bill more than one "always therapy" service (identified by CPT code) on the same day for the same patient, all therapy services beyond the first are subject to a reduction in the practice expense portion of that code.

  Under this policy, the therapy service with the highest practice expense value is reimbursed at 100%, and the practice expense values for all subsequent therapy services, provided by all therapy clinicians, are reduced by 50%. The work and malpractice components of the therapy service payment are not reduced. In the 2011 Medicare Physician Fee Schedule, CMS first proposed the implementation of a 25% MPPR across therapy services. Congress reduced this reduction amount to 20% in the Physician Payment and Therapy Relief Act of 2010 (H.R. 5712). This 20% MPPR was in place from Jan. 1, 2011, to March 31, 2013. Without any further analysis demonstrating a need to increase the MPPR, Congress implemented a permanent 50% MPPR in the American Taxpayer Relief Act of 2012, which was implemented by CMS on April 1, 2013. The average payment per therapy claim in 2013 (after MPPR) was 8.5% less than the average therapy claim in 2010 (before MPPR).

  APTA has opposed the MPPR policy since its inception. It is inherently flawed because the American Medical Association Relative Value Scale Update Committee, which assigns values to CPT codes, already ensures that any potential duplication in work or practice expense is addressed as part of the code valuation process. Certain efficiencies that occur when multiple therapy services are provided in a single session were explicitly taken into account when relative values were established for these

codes. The application of MPPR to the "always therapy" codes results in duplicative and excessive reductions of these codes and has a significant impact on the financial viability of therapy practices, ultimately affecting access to vital therapy services.

The percentage of payment reduction was arbitrarily determined by the 112th Congress and does not reflect actual utilization data on how many units of a therapy service are typically delivered in a treatment session, nor does it recognize that OT, PT, and SLP interventions are separate and distinct. When CMS first proposed the MPPR, they purposefully did not consider how therapy services are provided in facility-based settings, even stating that they did "not believe it would have been appropriate for us to consider institutional patterns of care." (See page 70).

With the potential exception of greeting the patient, clinical staff activities that are elements of the practice expense are not duplicative in nature and should not be reduced in value, especially when delivering different services during the therapy session. For instance, if therapeutic exercises using hand weights are provided for one unit, followed by self-care retraining in the kitchen for one unit, then the equipment, supplies, and clinical staff activities are entirely separate for each of these procedures. Each requires its own disinfection, patient positioning, and other set-up and clean-up processes before and after the procedure. Under the current policy, despite those services being separate and distinct, and having a separate and distinct practice expense, payment for the second unit is reduced even though the values of the two codes do not include any duplicative cost.

MPPR also applies across therapy disciplines delivered on the same date, regardless of the distinct services and supplies provided to the patient. While the first therapy discipline (e.g., physical therapy) would receive payment under MPPR at 100% for the first unit and 50% of the practice expense for all other units, a second or third discipline (e.g., occupational therapy or speech-language pathology) delivering services on that date would have all provided service units reduced. This occurs even though the expertise, equipment, clinical staff, and supplies utilized for one therapy service have no overlap with the other services provided. This policy penalizes providers when scheduling multiple therapies on the same date, which disproportionately affects beneficiaries in rural and underserved communities where transportation issues may require therapy services to be delivered on the same day

to reduce the need for repeat visits to the clinic. **APTA supports the RECOVER Act (H.R. 8386) legislation that would repeal the flawed MPPR policy.**

- **Provide Improved Transparency in the CPT Code Valuation Process.** The work of the American Medical Association Relative Value Scale Update Committee, or AMA RUC, is, in essence, the work of a federal advisory committee but is not subject to the requirements of the Federal Advisory Committee Act. Congress could make the RUC valuation process subject to this act or could create a specific set of transparency requirements specifically for the RUC. AMA confidentiality agreements and related restrictions should only be limited to voting details and should not apply to valuation surveys, policies, procedures, any other data collection, or debate. The lack of transparency in the AMA RUC processes used for CPT code valuation, and during the debate before a vote, creates a system that is easily politicized, potentially pits different health care specialties against one another in a fight over funds limited by budget neutrality, and makes it difficult to report concerns outside the process.

- **Congress Should Separate High-Value Procedures from the RUC Process and Remove These Procedures from Calculations of Budget Neutrality Under the Medicare Fee Schedule.** Since the establishment of the current relative value unit and rate-setting process, there has been a major shift in the services provided in outpatient settings. Services that used to be provided in the hospital under Medicare Part A are now being provided in outpatient settings under Medicare Part B. This increase in high-tech, high-cost services that used to be reimbursed under Part A is skewing relativity and squeezing lower-cost specialties because of budget neutrality.

- **Direct CMS to Exercise Greater Oversight of the CPT Code Valuation Process.** The process for valuing CPT codes is labor-intensive, complicated, and nuanced. The AMA RUC has developed the expertise to administer this process over more than 30 years. Despite this expertise, CMS sometimes rejects the RUC and RUC HCPAC recommendations, choosing to undervalue or not value codes that have gone through this extensive, complex AMA valuation process. This process requires dozens of hours of specialty society staff time as well as expert advisor time to prepare and present at numerous meetings for various stakeholders, including the Practice Expense Workgroup, the Research Subcommittee Workgroup, and the Relativity Assessment Workgroup, among others. CMS must be a stronger leader in the process and must exercise its oversight authority to ensure that, if it continues to place such extensive time and resource burdens on specialty societies, the code values put forward by the RUC are accepted by CMS.

To this end, Congress should direct CMS to do the following:

1. CMS should play a stronger role in the development of the rules and procedures used during the valuation and data collection process. This will help to ensure that CMS has the expertise on staff to confirm that policies and procedures are followed, provide appropriate oversight, and guarantee that the process is reflective of and equitable for all specialties that CPT codes for health care services.
2. CMS should establish an external appeals process that can be triggered before values are published in the Medicare Physician Fee Schedule proposed rule. For this reason, we support the reinstatement of a refinement panel. Currently, if CMS chooses to simply not value a code, or if CMS undervalues a code compared to the RUC recommendation, there is no process of appeal, except to submit a comment during the public comment period of the fee schedule proposed rule. This is an inadequate way to challenge a decision, given the complexity and time-intensive nature of the valuation process.
3. CMS should clarify how the list of reference codes (used for the purpose of establishing future relative values) should be developed. The reference list plays a crucial, but opaque, role in setting relative values.
4. CMS should develop an independent advisory panel to examine existing issues in the valuation process, analyze trends that might inappropriately skew relative values, and suggest ways the process may need to evolve to account for continued changes in the health care landscape, including innovations. For example, the current valuation process disincentivizes building in efficiencies to medical services, as those services are then devalued under the current process. Congress should give CMS the flexibility to implement the recommendations of such a panel.

Centers for Medicare and Medicaid Services (CMS) RFI: "Unleashing Prosperity Through the Deregulation of the Medicare Program."

As members of the Subcommittee are aware, last year, CMS published an RFI ("Unleashing Prosperity Through the Deregulation of the Medicare Program)" seeking input regarding current regulations that may be burdensome, outdated, or unnecessary, and should be reviewed for potential elimination or significant modification. In response to the RFI, APTA submitted extensive comments recommending the following measures

be implemented to better aid in the delivery of healthcare to Medicare patients and ease administrative burdens on providers:

- **Replace Medicare's 8-Minute Rule.** Under Medicare's 8-Minute Rule, introduced in Dec. 1999, rehabilitative therapists are required to add all service minutes across different CPT codes during a therapy session and apply a tiered decision matrix to determine unit billing. The rule is both confusing and time-consuming; the instructions and examples on applying the policy cover three pages in the Medicare Claims Policy Manual and are an oft-cited source of significant strain and uncertainty among therapy providers. APTA urges adoption of the AMA's Midpoint rule, a similar, but administratively simpler standard. Under the Midpoint Rule, each timed service is evaluated individually based on its time threshold, simplifying calculations and reducing billing errors.

- **Expand the Plan of Care Signature Exception to Direct Access Patients.** Previously, in addition to submitting the plan of care (POC) to the referring provider within 30 days of initial treatment, a PT was required to have that provider return a signed and dated copy of the POC as evidence of certification. However, in the CY 2025 Physician Fee Schedule rule and codified under the new 424.24(c)(5), once the PT has transmitted the POC, the onus is now on the referring provider to either return the signature or indicate changes. However, one major caveat is that only claims for services provided to patients with an order or referral are eligible for the exception. APTA recommends that this policy be expanded and applied to direct access patients to expedite the delivery of care.

- **Eliminate Enforcement of the KX Modifier.** Section 50202 of the Bipartisan Budget Act of 2018, P.L. 115-123 amended Section 1833(g) of the Social Security Act to repeal the application of the therapy caps. While APTA supported this removal, in lieu of the caps, Congress added limitations to the delivery of therapy services via the KX modifier threshold. Despite the removal of the hard cap on payment for therapy services, the SSA still requires the KX modifier to be appended to any claims exceeding the KX threshold, which is adjusted annually for inflation using the Medicare Economic Index. For physical, occupational, and speech therapists, if services delivered in a year exceed the annual threshold amount, the therapist must include the KX modifier on the patient's claims to confirm that services were medically necessary and are justified by the appropriate documentation. Claims for services over the KX modifier threshold amounts without the KX modifier are denied. Appending the KX modifier to

claims to support medical necessity for the purposes of payment is redundant and should no longer be enforced.

- **Create Consistent and Uniform Credentialing Procedures in Medicare Advantage:** Under 42 CFR 422.204, a Medicare Advantage Organization (MAO) is required to have written policies and procedures for the selection and evaluation of providers for network participation and follow this documented process with respect to initial credentialing. Likewise, commercial and other health plans are required under state law to follow similar requirements, essentially requiring the same information and data points from providers who enter into contracts to participate in their networks. Physical therapists credentialed by Medicare, therefore, undergo redundant credentialing by each MAO or other health plan they contract with for network participation. In addition to the extensive wait time and resulting impediment to access to care, physical therapy practices and facilities expend significant time and resources managing multiple credentialing applications, all collecting essentially the same duplicate documentation. Applying Medicare credentialing recognition across all MAOs and commercial insurance plans would result in faster patient access, lower administrative costs, greater provider mobility, improved continuity of care, and more robust networks in underserved areas

Conclusion

APTA appreciates the Subcommittee holding this hearing and for the opportunity to provide comments on these issues. Should you have any questions, please contact Steve Kline with APTA Congressional Affairs (stevekline@apta.org). Thank you for your time and consideration.

Sincerely,

Justin Elliott
Vice President, Government Affairs
American Physical Therapy Association

Appendix A: Recommended Draft Legislative Language to Reform QPP to Allow Broader Participation by Therapy Providers

SEC. 5. REFORMS FOR THERAPY PROVIDERS UNDER MACRA

SECTION 1848(K) OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395W-4) IS AMENDED BY INSERTING THE FOLLOWING:

(3) QUALITY MEASURES FOR USE BY PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS, OR A QUALIFIED SPEECH-LANGUAGE PATHOLOGISTS. —

(I) IN GENERAL. – THE SECRETARY SHALL ENSURE THAT ADEQUATE MEANINGFUL MEASURES ARE AVAILABLE FOR REPORTING BY REHABILITATION THERAPISTS FOR DIAGNOSES OR CONDITIONS EVALUATED, TREATED, AND MANAGED BY REHABILITATION THERAPISTS AND THAT THOSE MEASURES ARE NON-PROPRIETARY, CAN BE INTEGRATED INTO A VARIETY OF ELECTRONIC HEALTH RECORD SYSTEMS, AND PROVIDE ADEQUATE SENSITIVITY AND SPECIFICITY. NOTHING IN THE PRECEDING SENTENCE PROHIBITS THE USE OF PROPRIETARY MEASURES IN THE QPP.

(II) ADVISORY COMMITTEE.—

(A) IN GENERAL.—NOT LATER THAN 1 YEAR AFTER THE DATE OF THE ENACTMENT OF THIS SECTION, THE SECRETARY SHALL ESTABLISH AN ADVISORY COMMITTEE TO BE KNOWN AS THE 'NATIONAL OUTPATIENT THERAPY QUALITY ADVISORY COMMITTEE (IN THIS SUBSECTION REFERRED TO AS THE 'COMMITTEE') FOR PURPOSES OF CARRYING OUT THE DUTIES SPECIFIED IN SUBPARAGRAPH (B).

(B) DUTIES.—THE DUTIES OF THE COMMITTEE ARE THE FOLLOWING:

(I) TO PROVIDE TO THE SECRETARY RECOMMENDATIONS WITH RESPECT TO REQUIREMENTS THAT MAY BE DETERMINED APPROPRIATE BY THE SECRETARY PURSUANT TO PARAGRAPH (3(I)), INCLUDING ANY RECOMMENDATIONS ON PROPOSED REGULATIONS RELATED TO REFORMS FOR THE THREE INDIVIDUAL THERAPY DISCIPLINES. IN DEVELOPING SUCH RECOMMENDATIONS, THE COMMITTEE SHALL PRIORITIZE—

(I) FORMULATION OF RECOMMENDATIONS TO ENSURE AGREEMENTS WITH EXTERNAL CONTRACTORS TO DEVELOP MEASURES THAT ENSURE ALL APPLICABLE PROVIDERS ARE REPRESENTED IN THE TRIGGER/CONFIRMING CODES FOR THE MEASURE.

(II) DEVELOPMENT OF OPTIONS FOR THE ABILITY OF FACILITY-BASED REHABILITATION THERAPISTS TO PARTICIPATE IN THE QUALITY PAYMENT PROGRAM.

(III) IDENTIFICATION OF BARRIERS AND DEVELOPMENT OF RECOMMENDATIONS TO FACILITATE PARTICIPATION OF THERAPISTS IN THE QUALITY PAYMENT PROGRAM.

IV. CONSULT WITH MEASURE DEVELOPERS TO ENCOURAGE DEVELOPMENT OF MEASURES THAT REFLECT THE IMPACT OF REHABILITATION ON THE COST AND QUALITY OF CARE.

V. FORMULATION OF OPTIONS FOR THERAPY PROVIDERS TO BE EXEMPTED FROM THE CURRENT COST MEASURE REQUIREMENT UNDER THE QUALITY PAYMENT PROGRAM.

(C) COMPOSITION.—THE COMMITTEE SHALL BE COMPOSED OF NOT FEWER THAN 9 INDIVIDUALS SELECTED BY THE SECRETARY. SUCH INDIVIDUALS SHALL NOT BE OFFICERS OR EMPLOYEES OF THE FEDERAL GOVERNMENT AND SHALL INCLUDE—

(I) OCCUPATIONAL THERAPISTS NOMINATED BY THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION;

(II) PHYSICAL THERAPISTS NOMINATED BY THE AMERICAN PHYSICAL THERAPY ASSOCIATION;

(III) SPEECH-LANGUAGE PATHOLOGISTS NOMINATED BY THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION;

(IV) OTHER INDIVIDUALS DETERMINED APPROPRIATE BY THE SECRETARY, INCLUDING PATIENTS REPRESENTING EACH OF THE AFFECTED COMMUNITIES.

(D) MEETINGS.—THE COMMITTEE SHALL CONVENE NOT LESS THAN THREE TIMES EACH YEAR.

(III) REGULATIONS.— NOT LATER THAN 2 YEARS AFTER THE DATE OF THE ENACTMENT OF THIS SUBSECTION, THE SECRETARY PUBLISH PROPOSED REGULATIONS BASED ON THE RECOMMENDATION OF THE COMMITTEE.

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Statement for the Record

Energy and Commerce Health Subcommittee

Hearing on "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms"

May 20, 2026

Prepared by *Families USA*

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Chairs Guthrie and Griffith and Ranking Members Pallone and DeGette, on behalf of Families USA, thank you for holding this important and timely hearing.

Every family across our nation should have access to the health care they need at a price they can afford. Yet rather than being designed to deliver the highest-quality care for the lowest possible cost, the U.S. health care system is currently designed to rake in the highest possible profits for big health care corporations with little regard to health outcomes – all while millions of Americans struggle to afford their care.

Policymakers must take urgent action to realign the economic incentives of health care payment and delivery so that the health care sector only economically thrives when it is providing affordable, high-quality health care to our nation's families. The Energy and Commerce Committee should advance reforms that both immediately address the most egregious flaws in the Medicare physician payment system and build a strong foundation for longer term pathways to true accountability for the cost and quality of care and the health of families and patients.

Fee-For-Service Payment Driving Low-Quality, High-Cost Care

One of the biggest drivers of our nation's health care affordability and quality crisis is the way the U.S. pays for health care – a payment system largely based on fee-for-service (FFS) economics that drives the fragmented and poorly coordinated health care that the majority of our nation's families now experience. Fee-for-service payments incentivize health care providers to make money by performing higher volumes of high-profit or high-margin procedures, rather than by allowing providers to generate a profit or margin based on keeping people healthy and reducing disparities.[1] Ultimately, FFS payment not only drives up health care costs but has no relationship health care quality or improved health outcomes.[2] The effects of these broken FFS payment incentives are amplified through physician payment across the health care system and serve as the basis for Medicare payment – one of the largest and most important payers in U.S. health care – through the Medicare Physician Fee Schedule (MPFS). FFS payment incentives predominate in all forms of health insurance, including Medicare Advantage, Medicaid managed care, private insurance, traditional Medicare and Medicaid, and the majority of existing value-based payment models. Medicare payment policy, including the Medicare Physician Fee Schedule, is perhaps one of the most critical levers for shifting the country away from FFS economics towards a value-based payment system that drives improvements in health while containing health care costs.

Moreover, as Medicare spending and beneficiary out-of-pocket costs climb, the disparities embedded into the Medicare Physician Fee Schedule are amplified across our system. Flaws in how payments are established and disparities that value specialty care over primary care and behavioral health services continue to drive critical provider shortages and restrict access to the health care services many patients need.[3]

The shortcomings of fee-for-service payment are well-documented. Yet, despite more than 15 years of efforts to move away from FFS payment, most notably through enactment of Medicare Access and CHIP Reauthorization Act (MACRA) reforms and the implementation of dozens of new payment and delivery models, the majority of health care reimbursement still flows through FFS

payments.[4] Now is the time for Congress to reform the way we pay for health care and to accelerate meaningful payment reform efforts that hold providers accountable for the total cost of health care and improving population health outcomes. These policy reforms must focus both on making critical improvements to the MPFS and strengthening the pathways for more providers to shift into full risk, population-based payment models. Ultimately, lawmakers must work towards establishing population-based payments as the core reimbursement model for health care services through Medicare.

Physician Payment Rate Setting in the Medicare Physician Fee Schedule

Addressing the flaws of the MPFS is critical to both improving current physician reimbursement and advancing the move towards a value-based health care system. Existing flaws in the MPFS undermine access to high-value health care and contribute to overspending on select specialty care.[5] The most significant flaws include:

1. **Conflicts of interest in the payment update process:** Updates to MPFS service valuation have historically been informed by recommendations from the American Medical Association's Relative Value Update (RVU) Committee (RUC), which relies on survey data from physician specialty associations. The nonpartisan experts at the Government Accountability Office and the Medicare Payment Advisory Commission have repeatedly sounded the alarm that the specialists sitting on the RUC have a financial interest to inflate their estimates, leading to biased estimates of RVUs and distorted fees.[6, 7] Evidence shows that fees for procedures, imaging and tests are priced too high, and fees for time spent with patients are priced too low, creating a massive distortion in the MPFS. The result is that specialty care is often overvalued at the expense of primary care leading to higher reimbursement for specialty care while further deepening the historic under payment of primary care.[8] Ultimately, the use of the RUC in creating price determinations results in payments that are in the best interests of specialty providers rather than what is in the best interest of consumers.
2. **Distortions in payment across specialties:** Evidence shows that the periodic updates informed by the RUC and used by CMS to establish payments for services have resulted in prices that do not accurately reflect the resources needed to deliver such services, causing some services to be overvalued and priced higher, and others to be undervalued and priced lower.[9] Specifically for primary care and behavioral health care providers, the time-intensity required to meet patients' needs and the critical thinking and judgement required to manage the health and wellbeing of an increasingly medically complex and aging population are not well represented in the payments established in the MPFS. Wide disparities in compensation persist in the fee schedule,[10] contributing to a growing primary care, geriatric medicine, and behavioral health care provider shortage. [11]

In recognition of the need to correct the significant distortions in the MPFS, the Calendar Year 2026 (CY26) MPFS final rule took important steps to address the flaws in how Medicare establishes payment rates that have driven overpayments for hospital and specialty care at the expense of primary care and independent practices. These reforms included reducing reliance on the AMA

survey data and updating the physician payment rate-setting methodology to reflect changes in the health care system and gains in efficiency in the delivery of many professional services. These changes will push more dollars into primary care practices that deliver higher-value, lower-cost care to millions of Americans and work to address a key incentive of health care consolidation. **It is critical Congress supports these efforts and opposes legislation like the Efficiency Adjustment Delay Act (H.R.7520), which seeks to undermine the progress made in final CY26 MPFS.**

Shortcomings of MACRA and the Quality Payment Program

Concerns from policymakers and advocates around the role that fee-for-service economics play in driving up health care spending with little accountability for the quality or efficiency of care delivery are not new. The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the deeply flawed Medicare Sustainable Growth Rate (SGR) and created new financial incentives that aimed to shift physician payment away from FFS and towards value-based care through the Quality Payment Program (QPP).

However, nearly a decade after implementation, there are significant concerns about whether the QPP — and the Merit-Based Incentive Payment System (MIPS) in particular — is meeting the intended goal to drive toward high-value health care and into advanced alternative payment models (AAPMs). A major challenge of MIPS is that providers can game the system and self-select which performance measures they're evaluated on, allowing them to report favorably without meaningfully changing their behavior.[12] There is also robust evidence that pay-for-performance programs have little to no success in shifting financial incentives or consistently improving care quality.[13] Ultimately, the MIPS payment adjustments continue to be rooted in FFS economics, meaning that under the MIPS program, the financial incentives still reward providers for higher care volume rather than higher care quality and improved health. Overall, providers have little incentive to move from MIPS into AAPMs where they are truly accountable for the cost and quality of care they provide. As a result, MIPS has failed as an on ramp to these models, evidenced by the fact that over 50% of traditional Medicare payments continue to flow through traditional fee-for-service payments.[14]

The Promise of True Payment Reform

The ability of payment reform to fulfill its promise hinges on inverting the economics of the health sector's business model to enable the sector to generate revenue by keeping people healthy and ensuring health care is affordable, rather than by billing for unnecessary visits and procedures and engaging in anti-competitive behavior and price gouging.[15] The key ingredient to successful payment reform is making it economically advantageous for health care providers to address whole-person health needs. In other words, there must be a viable business model for providers to make the switch to non-FFS payment models, such as population-based payments, which hold providers accountable for health outcomes and the total cost of patient care.

Population-based payment models are based on paying one health care provider — typically a primary care organization or a health system — a single monthly payment, out of which the organization then pays for some or most health care costs for a whole population. Such payment arrangements are coupled with strong quality and outcome metrics to ensure that as providers'

economics change, patients' health thrives. In this way, providers are "at risk" for care that is wasteful and does not improve or protect patients' health but make money when they are efficient and improve or protect patients' health. This model, therefore, is structured to incentivize providers to deliver well-coordinated, high-quality, person-centered care. And the payments can be used to cover a wide range of services, including preventive health, care coordination, wellness services and services that address the social determinants of health, as well as standard medical procedures and services.[16]

Recommendations for Congress

Reforming and strengthening the way physicians are paid is foundational to moving our health care system to one that provides the high quality, affordable health care and the improved health that our nation's families deserve. We urge the Energy and Commerce Committee to focus on policy solutions that address the underlying distortions in the Medicare Physician Fee Schedule while continuing to advance reforms that transform our health care system to one in which providers are held accountable for health outcomes and the total cost of care through population-based payments.

We encourage you to work with colleagues in the House and Senate to:

- **Create an independent technical advisory committee** tasked with collecting, developing, and assessing empirical data to inform the valuation of health care services in the MPFS to serve as an alternative to the Relative Value Update Committee.
- **Direct CMS to correct misvalued services** in the fee schedule to address distortions that have resulted in the overpayment of select specialty services and undervaluing of the services critical to meeting consumer needs, such as primary care and behavioral health.
- **Reform MACRA to better prepare and move providers into AAPMs**, by:
    - Replacing the Merit-Based Incentive Program with a new value-based program with a clear set of standardized meaningful quality and outcome measures. More specifically:
        - Establish streamlined, specialty specific, mandatory quality measures that prevent providers from self-selecting into quality measures they will perform best in.
    - Mandating providers move on a faster glidepath into AAPMs to ensure a meaningful and timely shift to non-fee-for-service models.
- **Establish population-based payments as the core Medicare reimbursement structure,** by:
    - Increasing CMS' authority to create prospective, population-based payments in the MPFS.
    - Creating hybrid payment models through the Medicare Physician Fee Schedule such as for primary care payment through passage of the Pay PCPs Act.
    - Mandating the Center for Medicare and Medicaid Innovation (CMMI) expands efforts to test mandatory payment models in which providers are required to participate.
    - Directing CMMI to increase the number of population-based payment models and full-risk models including global hospital budget and multi-payer models operated.

Conclusion

Thank you again for holding this hearing on better aligning the economic incentives of the health care sector with the needs of consumers and families. Ultimately, policy solutions should reorient health care payment and delivery to the goal that we all have — improved health for ourselves and our families that is affordable and economically sustainable. The journey to fully transforming our health care system is long, but Congress holds the power to take the next critical steps. Families USA stands ready to support you in this essential and urgently needed work. Please contact Jane Sheehan, Deputy Senior Director of Federal Relations at Families USA, JSheehan@familiesusa.org, for further information and to let us know how we can best be of service to you.

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[1] Health Care Payment Learning & Action Network, *Alternative Payment Model APM Framework* (MITRE Corporation, 2017), http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

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[4] AHIP, *2025 APM Measurement: Progress of Alternative Payment Models, 2026,* https://www.ahip.org/resources/2025-apm-measurement

[5] Laura Skopec, Robert A Berenson, Why the Medicare physician fee schedule misvalues fee levels and how to fix it, *Health Affairs Scholar*, Volume 3, Issue 10, October 2025, qxaf189, https://doi.org/10.1093/haschl/qxaf189

[6] Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy, GAO-15-434, U.S. Government Accountability Office (GAO), May 2015, https://www.gao.gov/products/gao-15-434

[7] Medicare Payment Advisory Commission, *Report to the Congress, MedPAC*, June 2018, Chapter 3: Rebalancing Medicare's Physician Fee Schedule Toward Ambulatory Evaluation and Management Services", https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf.

[8] Medicare Payment Advisory Commission, *Report to the congress: Medicare and the Health Care Delivery System. Washington, DC: MedPAC*; June 2011, Chapter 1, sustainable growth rate system, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Jun11_Ch01.pdf; see also, Robert Berenson, and Kevina Hayes, The Road to value Can't Be Paved With A Broken Medicare Physician Fee Schedule, *Health Affairs Scholar* , Volume 43, Number 7, July 1, 2024, https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00299

[9] Medicare Payment Advisory Commission, *Report to the Congress, MedPAC*, June 2018*, Chapter 3: Rebalancing Medicare's Physician Fee Schedule Toward Ambulatory Evaluation and Management Services*, https://www.medpac.gov/wp-content/uploads/import_data/scrape_ files/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf

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[11] Health Resources and Services Administration, *State of the Primary Care Workforce,* National Center for Health Workforce Analysis, December 2025,https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-the-Primary-Care-Workforce-2025.pdf

[12] Matthew Fiedler et al., "Congress Should Replace Medicare's Merit-Based Incentive Payment System," University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics, February 27, 2018, https://healthpolicy. usc.edu/article/congress-should-replace-medicares-merit-based-incentive-payment-system/

[13] Aaron Mendelson et al., "The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care: A Systematic Review," Annals of Internal Medicine 166, no. 5 (January 2017): 341–353, https://www.acpjournals. org/doi/10.7326/M16-1881.

[14] AHIP, *2025 APM Measurement: Progress of Alternative Payment Models, 2026,* https://www.ahip.org/resources/2025-apm-measurement

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[16] Health Care Payment Learning & Action Network, *Alternative Payment Model APM Framework* (MITRE Corporation, 2017), http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

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Statement for the Record

House Committee on Energy and Commerce Subcommittee on Health

Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reform

Wednesday, May 20, 2026

Ann Greiner,
President and CEO,
Primary Care Collaborative

Thank you to Health Subcommittee Chairman Griffith, Ranking Member DeGette, Full Committee Chairman Guthrie, Ranking Member Pallone, and members of the House Energy and Commerce Committee for holding this important hearing today. The Primary Care Collaborative is a national nonprofit that unifies voices from across the entire health landscape to advocate for better health and wellbeing of all Americans by strengthening primary care. PCC's member organizations are united by one overarching truth: when people have access to high-quality, whole-person primary care, their health improves and costs fall—both for consumers, but also for the rest of the health system *and* taxpayers. Unfortunately, decades of reliance on flawed fee-for-service reimbursement methodologies have left primary care access at a tipping point with wait times measured in months in some geographies.[1]

To change this, Medicare must move decisively to expand viable pathways beyond fee-for-service. That begins with properly valuing whole-person primary care and scaling viable primary care payment alternatives to fee-for-service.

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[1] Beetham, Tamara, Trisha Marsh, Michael L Barnett, Ruby M Aaron, Emmanuel Greenberg, Alexandra Do, and Jane M Zhu. "Medicare Appointment Availability and Wait Times Vary Considerably Across Four Large US Urban Markets." *Health Affairs Scholar* 4, no. 3 (March 1, 2026): qxag054. https://doi.org/10.1093/haschl/qxag054.

Decades of research have demonstrated the transformative power of primary care. The evidence suggests that strong investment in primary care promotes better outcomes,[2] generates savings[3] and—most importantly—prevents illness, enables healthier lives and lengthens longevity.[4]

But, today, more Americans are struggling to access the primary care they need and deserve. Evidence—including the Milbank Memorial Fund's latest Primary Care scorecard—show that about 30% of Americans don't have a continuous relationship with a primary care team or clinician that they trust.[5] About 27% of Americans live in a region experiencing a shortage of primary care clinicians, even more prominent in rural areas.[6] And those who do have access to care often experience long waits for appointments or limited time with their primary care clinicians.

At the same time, more Americans are seeking care in expensive settings—including urgent care and emergency departments[7]—or deferring care altogether. Unsurprisingly, chronic conditions are on the rise, imperiling Americans health and costing taxpayers $4.4 trillion annually[8]. In short, these access challenges have contributed to a health system that is focused on delivering high-cost, reactive treatments rather than proactive care that can prevent chronic diseases from developing.

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[2] Mark W. Friedberg, Peter S. Hussey, and Eric C. Schneider, "Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care," *Health Affairs* 29, no. 5 (May 1, 2010): 766–72, https://doi.org/10.1377/hlthaff.2010.0025.

[3] Dilara Sonmez, George Weyer, and Daniel Adelman, "Primary Care Continuity, Frequency, and Regularity Associated With Medicare Savings," *JAMA Network Open* 6, no. 8 (August 21, 2023): e2329991, https://doi.org/10.1001/jamanetworkopen.2023.29991.

[4] Barbara Starfield, Leiyu Shi, and James Macinko, "Contribution of Primary Care to Health Systems and Health," *Milbank Quarterly* 83, no. 3 (September 1, 2005): 457–502, https://doi.org/10.1111/j.1468-0009.2005.00409.x.

[5] "Percentage of adults without a usual source of health care (MEPS Data)." 2026 Primary Scorecard Data Dashboard, Milbank Memorial Fund, Feb. 2026, https://www.milbank.org/primary-care-scorecard/.

[6] Calculation based off of "Designated Health Professional Shortage Areas Statistics," Bureau of Health Workforce, HRSA, accessed March 24, 2026, https://data. hrsa.gov/topics/health-workforce/shortage-areas and "Annual Estimates of the Resident Population for the United States", U.S. Census Bureau, Jan. 2026, https:// www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html

[7] Centers for Disease Control and Prevention, "Trend Tables Health, United States, 2020–2021," *Table EDAd. Emergency Department Visits Within the Past 12 Months Among Adults Aged 18 and Over, by Selected Characteristics: United States, Selected Years 1997–2019,* 2021, https://www.cdc.gov/nchs/data/hus/2020-2021/EdAd.pdf.

[8] Centers for Disease Control and Prevention, "Fast Facts: Health and Economic Costs of Chronic Conditions," https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html

These access challenges are a direct result of the undervaluing of and underinvestment in primary care. Despite accounting for roughly half of all office visits,[9] primary care accounts for less than 5 percent of all health spending—and the funding shortage is particularly acute in Medicare, where primary care is only 3.7% of spending.[10]

But we don't have to settle for this broken, reactive, sick-care system. And we don't have to keep building bureaucracies that burden primary care with hassles and paperwork that neither increase quality nor reduce costs. By changing how and what we pay primary care, we can ensure that care teams have the resources, infrastructure and *time* they need to spend with patients. We can empower Americans and their families to build strong, trusting relationships with clinicians who understand *all* their health needs and partner with them to effectively manage them.

SUMMARY OF POLICY RECOMMENDATIONS

1) **Properly Value Primary Care**: Congress must address the persistent undervaluation of primary care that drives inadequate investment in primary care. It is also vital that CMS explore alternative data sources, beyond surveys, to gain a more complete understanding of the value of different services. Pairing stronger investment with proper valuation going forward can help reverse trends that have contributed to workforce shortages exacerbating access issues across the nation.
2) **Implement Hybrid Payments**: Congress should pair stronger investment in primary care with a smarter approach to payment by implementing hybrid payments, as recommended by the National Academies of Science, Engineering and Medicine.[11] Hybrid payments provide primary care with fixed, regular upfront payments to help meet usual health needs of their patients—such as preventing chronic disease and chronic disease complications—while also providing additional fees for high-value, underprovided services. Shifting away from the broken fee-for-service chassis is essential if policymakers want to focus on promoting better health by fostering whole-person care. Primary care-focused ACO models and partnerships in Medicare Advantage—many enabled

[9] "National Ambulatory Medical Care Survey: 2019 National Summary Tables", Centers for Disease Control, 2019, https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2019-namcs-web-tables-508.pdf
[10] Milbank Memorial Fund, "2026 Primary Care Scorecard Data Dashboard | Milbank Memorial Fund."
[11] National Academies Of Sciences Engineering, And Medicine, "Implementing High-Quality Primary Care," (*The National Academies Press*, May 4, 2021), https://doi.org/10.17226/25983.

with alternative payment models—show improvements in quality while slowing costs.[12]

3) **Reform and Cut Red Tape in MIPS**: Policymakers must address burdensome red tape created by the MIPS program by simplifying and refocusing quality metrics on what matters, including continuity of relationships and comprehensiveness of services. Developing a simpler, and where possible outcome-focused, approach to quality measures—and potentially aligning with other payers—could help eliminate hours of unnecessary paperwork.
4) **Eliminate Cost Sharing for Primary Care**: Finally, Medicare beneficiaries need your help to remove unnecessary cost-sharing barriers to primary care. These barriers to care create administrative friction, places needless financial burdens on accessing high-value care for American families and prevent far too many people on Medicare from seeking the type of preventive care essential to better health. Eliminating these barriers is particularly important for expanding care management and integrated behavioral health services, which play a critical role in keeping people healthy.
5) **Ensure Whole Person Care**: Primary care should be comprehensive, coordinated and relationship-based. To support patients in successfully achieving their health goals, practices must have the resources and staff to respond, address and coordinate physical, behavioral and social care across multiple settings. Stronger primary care teams should include behavioral health clinicians, pharmacists, social workers and care managers capable of supporting patients with chronic disease and behavioral health - and connect them to social care and community resources.

1) Properly Value Primary Care

The PCC believes the Medicare Physician Fee Schedule (MPFS) structurally disadvantages primary care by systematically overvaluing procedures, imaging and testing while undervaluing cognitive, relationship-based, time-intensive services. This

[12] Primary Care Collaborative, "Make Medicare Beneficiaries Healthier by Strengthening Primary Care," (March 2025), https://thepcc.org/wp-content/uploads/2025/03/Make-Medicare-Beneficiaries-Healthier-Issue-Brief.pdf.

mis-valuation contributes to primary care workforce instability, practice closures and worsening access to care.

Medicare reimburses physicians 3 to 5 times more for common procedures than for cognitive-focused care,[13] even though primary care clinicians manage complex chronic disease, coordinate care across multiple settings and support long-term patient relationships.

Current valuation methods rely too heavily on outdated survey data, fail to account for procedural efficiency gains and overlook the growing complexity of chronic disease management and the importance of sustaining continuous patient relationships in primary care. MPFS reform is necessary to rebalance value toward time and relationships and to better support prevention, behavioral health integration and chronic disease care.

The PCC supports reforms implemented by the CY 2026 Medicare Physician Fee Schedule, including the efficiency adjustment, greater use of empirical data and a site-of-service differential favoring community-based practices and asks policymakers to continue to build upon these important reforms in 2027.

Along with these investments, PCC believes Medicare's budget-neutrality requirements undermine meaningful investment in primary care because increases in primary care reimbursement often require offsetting cuts elsewhere in the Physician Fee Schedule. The zero-sum budget-neutrality requirements applicable to the Physician Fee Schedule should not undermine the scope and viability of substantial reforms. To invest more robustly in primary care without forcing reductions in other primary care services, Congress must update the MPFS budget neutrality threshold to reflect inflation. This threshold has been set at $20 million and has not been adjusted since its establishment in the 1990s. We urge lawmakers to require that this threshold be adjusted automatically going forward. Congress should also address persistent overestimation issues by instructing CMS to revisit assumptions used in calculating budget neutrality adjustments retroactively. Additionally, to meet its oversight responsibilities, Congress should direct the Government Accountability Office to compare CMS utilization estimates for new Medicare codes with actual utilization and payments after implementation, and to report its findings to Congress by a specified deadline.

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[13] Sinsky, Christine A, and David C Dugdale. "Medicare payment for cognitive vs procedural care: minding the gap." *JAMA internal medicine* vol. 173,18 (2013): 1733-7. doi:10.1001/jamainternmed.2013.9257

2) Implement Hybrid Payment Models

The PCC believes fee-for-service payment discourages prevention, care coordination and comprehensive chronic disease management because it rewards volume, particularly of higher priced services, rather than longitudinal patient relationships. That is why the PCC has encouraged Congress and the Administration to make hybrid payments available to primary care.

While we are grateful that the CMS Innovation Center has made important strides by rolling out models testing hybrid payments, we encourage Congress and Medicare to explore how to make hybrid payments broadly available across the permanent Medicare program.

The PCC's vision for hybrid payment is to combine upfront payments with ongoing fee-for-service reimbursement for selected services, enabling clinicians to build multidisciplinary care teams and spend more time with patients. This model supports services often left uncompensated or undercompensated under fee-for-service, including care coordination, behavioral health integration, patient communication, nutrition counseling and community-based support.

This approach, if properly resourced:

1. Provides more stable funding needed to attract and retain primary care clinicians;
2. frees clinicians to spend more time with patients by minimizing incentives that have led to squeezing more and more patient visits into the workday;
3. and allows primary care to build out care teams capable of delivering care for the whole person, including mental health, nutrition and lifestyle change.

PCC supports transitioning Medicare primary care payments from a predominantly fee-for-service approach to prospective, appropriately resourced population-based/hybrid payment models and to capitation for those practices ready to accept such risk.

3) Reform and Cut Red Tape in MIPS

While PCC supports the underlying goal of shifting from fee-for-service to value-based care that led to the establishment of Merit-based Incentive Payment System (MIPS), the reality is that, today, MIPS is a barrier to achieving that goal.

The wide swathe of measures—which rarely align with quality reporting for other payers—present a significant burden on primary care. These administrative reporting tasks eat up valuable time that would better be spent with patients and contribute to clinician burnout, ultimately exacerbating existing access issues.

The first, most immediate task is to provide relief from these burdens. Congress should minimize MIPS reporting requirements for those primary care teams participating in value-based care by reducing reporting requirements for clinicians participating in Alternative Payment Models or adopting Advanced Primary Care Management (APCM) codes.

Looking ahead, PCC urges Congress and the Administration to explore still more ambitious steps to simplify and streamline performance measurement. Working to align measures with private payers and across federal programs would help eliminate redundancy and simplify the red tape primary care must navigate while filing claims.

Finally, it is essential to develop metrics that measure health and those characteristics of care that are most strongly associated with health, like continuity and comprehensiveness of primary care.

4) Eliminate Cost-Sharing for Primary Care Services

Beneficiary cost-sharing creates unnecessary barriers to primary care, including behavioral health care and chronic disease management. Applying coinsurance to services such as APCM, behavioral health integration and chronic care management discourages uptake and adds administrative complexity for practices.

PCC supports waiving cost-sharing for services covered under hybrid payment arrangements and removing financial barriers to behavioral health integration and chronic disease management codes. By reducing cost-sharing, beneficiaries would be encouraged to seek upstream care earlier and more consistently, improving outcomes and reducing downstream spending.

The development and introduction of legislation to remove cost-sharing for APCM and associated behavioral health integration add-on codes would be an essential step toward increasing access to primary care.

5) Ensure Whole-Person Primary Care

The PCC believes behavioral health integration is essential to effective whole-person primary care because behavioral health conditions frequently co-occur with chronic

physical illness and significantly increase total health care spending. Nearly 1 in 4 Medicare beneficiaries lives with a mental illness, and that 75% of primary care visits include behavioral or mental health components.

Evidence-based models, such as the Collaborative Care Model and the Primary Care Behavioral Health model, can improve depression outcomes, reduce emergency department utilization, and strengthen chronic disease management.

Yet Medicare's existing behavioral health integration codes have seen low uptake because of burdensome time-tracking requirements, insufficient reimbursement and beneficiary co-pays.

The PCC supports enhanced reimbursement, technical assistance and elimination of cost-sharing to make integrated care financially viable for primary care practices, particularly in rural and underserved communities.

As a first step toward the accelerated adoption of integrated care, th**e** PCC urges this Committee to mark-up and report HR. 2509, the COMPLETE Care Act.

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The PCC and our members are grateful to the Committee for their efforts to improve Americans' health by strengthening the Medicare program, and we appreciate the chance to demonstrate why centering primary care must be central in those efforts.

The PCC and its members stand ready to work with Congress to develop solutions that provide Medicare beneficiaries with the high-quality, whole-person primary care that they deserve.

Revisiting the Time Needed to Provide Adult Primary Care

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BACKGROUND: Many patients do not receive guideline-recommended preventive, chronic disease, and acute care. One potential explanation is insufficient time for primary care providers (PCPs) to provide care.
OBJECTIVE: To quantify the time needed to provide 2020 preventive care, chronic disease care, and acute care for a nationally representative adult patient panel by a PCP alone, and by a PCP as part of a team-based care model.
DESIGN: Simulation study applying preventive and chronic disease care guidelines to hypothetical patient panels.
PARTICIPANTS: Hypothetical panels of 2500 patients, representative of the adult US population based on the 2017–2018 National Health and Nutrition Examination Survey.
MAIN MEASURES: The mean time required for a PCP to provide guideline-recommended preventive, chronic disease and acute care to the hypothetical patient panels. Estimates were also calculated for visit documentation time and electronic inbox management time. Times were re-estimated in the setting of team-based care.
KEY RESULTS: PCPs were estimated to require 26.7 h/day, comprising of 14.1 h/day for preventive care, 7.2 h/day for chronic disease care, 2.2 h/day for acute care, and 3.2 h/day for documentation and inbox management. With team-based care, PCPs were estimated to require 9.3 h per day (2.0 h/day for preventive care and 3.6 h/day for chronic disease care, 1.1 h/day for acute care, and 2.6 h/day for documentation and inbox management).
CONCLUSIONS: PCPs do not have enough time to provide the guideline-recommended primary care. With team-based care the time requirements would decrease by over half, but still be excessive.

KEY WORDS: Team based care; Primary care; Preventive care; Chronic disease care; Population health.

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INTRODUCTION

Patients benefit from guideline-based preventive, chronic disease, and acute care,[1, 2] but many do not receive it.[3] A limitation to providing high-quality care is insufficient time.[4, 5] In 2003, Yarnall et al. estimated it would take 7.4 h/day for a primary care provider (PCP) to provide preventive care for a 2500 patient panel.[6] A study by Privett et al. found it would take 8.6 h/day.[7] A complementary study in 2005 by Østbye et al. calculated 10.6 h/day were needed for a PCP to manage the top ten chronic diseases.[8] These studies suggested at least 18 h/per day are needed for a PCP to provide preventive and chronic care management, not accounting for other tasks.

Since 2005, there have been changes in the structure of primary care. Traditionally, PCPs cared for patients primarily by themselves. However, new team-based care models, such as the Comprehensive Primary Care Initiative Plus (CPC+), increasingly involve other care providers in providing patient care.[9–11] Many healthcare organizations have encouraged this shift; for example, a National Academy of Medicine report urged new payment models to "pay for primary care teams to care for people, not doctors to deliver services."[12] These models may save PCP time by shifting tasks traditionally performed by the PCP to other members of the care team. Theoretically, the time savings may allow PCPs to focus on more advanced care, see more patients, or increase the delivery of guideline-based care. Because of the potential for team-based care to change primary care practice, we re-investigated the amount of time needed to provide preventive, chronic disease, and acute care without and with team-based care.

METHODS

Patient Panels and Study Design

Two recent surveys of family practice physicians calculated their average patient panel sizes as approximately 2300[13] and 2900[14] patients, respectively. A recent meta-analysis determining the optimal panel size was inconclusive, but panels ranged from 1200 to 3600.[15] Given the uncertainty in the literature, we modeled patient panels of 2500 patients, and varied this assumption in sensitivity analysis. We created 1000 hypothetical panels of 2500 patients from the 5856 adult participants in the National Health and Nutrition Examination

Survey (NHANES) 2017–2018 cohort.[16] The chances of inclusion in the panels were proportional to each participant's sampling weight,[17] and each individual selected from the survey to include in a panel was replaced into the survey prior to selecting the next patient. For each panel, we quantified the time needed to address preventive, chronic disease, and acute care assuming the PCP worked alone and with a multidisciplinary team (Fig. 1).

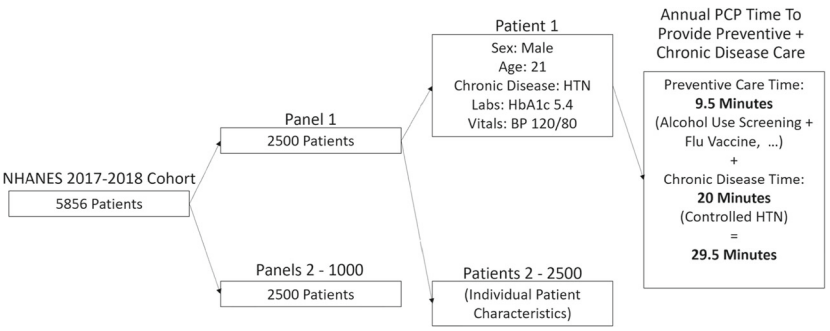
Primary Care Services

Preventive Care. We included the Grade A and B preventive care services and immunizations recommended by the United States Preventive Services Task Force (USPSTF) and Advisory Committee on Immunization Practices (ACIP), respectively, in 2020 (Appendix Table 1).[14, 15] For each preventive care service and immunization, we determined each NHANES participant's eligibility based on their age, gender, and presence of chronic conditions/comorbidities. Information to determine eligibility for all services were publicly available in NHANES 2017–2018, except for sexual history, for which we substituted the distribution of responses from the publicly available NHANES 2015–2016 data. For each NHANES participant, we calculated the annual time needed to provide preventive care based on the annual time required for each service they were eligible for (Fig. 1). If the PCP could provide the service herself, that time was calculated. If the service required a referral, the time required for the PCP to coordinate the referral was calculated. These times were summed for each participant to calculate the annual time needed to provide preventive care for each hypothetical panel of 2500 patients.

The total annual time for each service was calculated based on USPSTF guidelines, their citations, and a literature search (Appendix Table 2) describing their annual visit frequency and time per visit. For the literature search, we prioritized in order meta-analyses, clinical trials, review articles, and cohort or case studies. If we found no evidence, we assumed the service would take the same amount of time as another similar service (Appendix Table 2). If a service required screening and follow-up care, the time for both components was calculated independently. If screening resulted in the diagnosis of a chronic disease, we assumed that time would be part of chronic disease care (see below).

Because of heterogeneity in data availability for time estimates, we classified the quality of evidence as "strong," "moderate," or "weak," depending on the evidence source (Table 1). Data from a meta-analysis or randomized control trial was considered "strong"; evidence from cohort or case studies was considered "moderate." Weak evidence was based on expert opinion or author estimates. If estimates from a similar service were used, we downgraded the strength of evidence by one level.

Chronic Disease Care. We selected the ten most prevalent chronic diseases based on published data from the 2014 Medical Expenditure Panel Survey (Table 1).[18] We defined each chronic disease using NHANES data (Appendix Table 3), distinguishing between "controlled" and "uncontrolled" disease based on lab or physical exam data (such as a HbA1c >7 for diabetes). Then, for each participant in NHANES, we assessed whether they had each chronic disease, and whether it was "controlled" or "uncontrolled." The annual time needed to address each chronic disease for each patient was based on the annual visit frequency, which varied based on whether the disease was controlled or uncontrolled, and the time per visit. These times were summed for each participant to calculate the annual time needed to provide chronic disease care for each hypothetical panel.



Note: From left to right, graphic displays the creation of patient panels from the NHANES dataset, the unique patients comprising each panel, and the calculation of preventive and chronic disease care time for a sample patient based on his unique NHANES data. Graphic only displays 2 panels of the 1000 panels created from the NHANES dataset. Only 1 patient out of the 2500 patients in Panel 1 are displayed. Calculation for annual PCP time to provide care was only displayed for one patient out of the 2500 patients in panel 1.

Abbreviations: NHANES: National Health And Nutrition Examination Survey. HTN: Hypertension. HbA1c: Hemoglobin A1c. BP: Blood pressure. PCP: Primary Care Provider.

Fig. 1 Schematic displaying the creation of patient panels from an NHANES cohort, and the calculation of annual PCP preventive and chronic disease care time

Table 1 Estimated Time Needed to Provide Guideline Based Preventive and Chronic Disease Care for an Average US 2500 Adult Patient Panel

		PCP only care	Team based care[a]		Strength of evidence for time estimates[b]
		PCP time (h/day)	PCP time (h/day)	Non PCP time (h/day)	
Preventive care services	Weight loss to prevent obesity related morbidity and mortality in adults: counseling	4.11	0.34	3.77	Strong
	Healthy diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors: behavioral counseling interventions	2.36	0.20	2.16	Moderate
	Unhealthy alcohol use in adults: counseling	1.77	0.30	1.48	Strong
	Abnormal blood glucose and type 2 diabetes mellitus: counseling	1.39	0.12	1 27	Moderate
	Tobacco smoking cessation in adults: counseling	0.89	0.15	0.74	Strong
	Sexually transmitted infections: behavioral counseling	0.74	0.12	0.62	Strong
	Unhealthy drug use: counseling	0.47	0.08	0 39	Strong
	Depression in adults: screening	0.31	0.00	0 31	Moderate
	Intimate partner violence, elder abuse, and abuse of vulnerable adults: counseling	0.18	0.01	0.17	Strong
	Statin use for the primary prevention of cardiovascular disease in adults: counseling	0.18	0.18	0.00	Strong
	Weight loss to prevent obesity related morbidity and mortality in adults: screening	0.17	0.00	0.17	Strong
	Unhealthy alcohol use in adults: screening	0.17	0.00	0.17	Strong
	Tobacco smoking cessation in adults: screening	0.17	0.00	0.17	Strong
	Unhealthy drug use: screening	0.17	0.00	0.17	Strong
	Cervical cancer: screening	0.15	0.06	0.09	Moderate
	Hypertension in adults: screening	0.12	0.00	0.12	Weak
	Lung cancer: screening	0.10	0.10	0.00	Moderate
	Statin use for the primary prevention of cardiovascular disease in adults: screening	0.09	0.09	0.00	Strong
	Depression in adults: referral	0.09	0.09	0.00	Moderate
	Influenza vaccine	0.09	0.00	0.09	Weak
	Falls prevention in community dwelling older adults: screening	0.07	0.07	0.00	Moderate
	Intimate partner violence, elder abuse, and abuse of vulnerable adults: screening	0.05	0.00	0.05	Strong
	Skin cancer prevention: behavioral counseling	0.05	0.05	0.00	Moderate
	Latent tuberculosis infection: screening	0.03	0.00	0.03	Moderate
	Colorectal cancer: screening	0.03	0.03	0.00	Strong
	Abnormal blood glucose and type 2 diabetes mellitus: screening	0.03	0.00	0.03	Moderate
	Breast cancer: screening	0.02	0.02	0.00	Moderate
	Screening for chlamydia	0.01	0.00	0.01	Moderate
	Screening for gonorrhea	0.01	0.00	0.01	Moderate
	Hepatitis B virus infection in adults: screening	0.01	0.00	0.01	Moderate
	Prevention of human immunodeficiency virus infection: preexposure prophylaxis	0.01	0.01	0.00	Moderate
	Tetanus, diphtheria, pertussis vaccine	0.01	0.00	0.01	Weak
	Osteoporosis to prevent fractures: screening	0.01	0.01	0.00	Moderate
	Screening for syphilis infection in nonpregnant adults	0.01	0.00	0.01	Moderate
	Aspirin use to prevent cardiovascular disease and colorectal cancer: counseling	<0.01	<0.01	0.00	Strong
	Human papillomavirus vaccine	<0.01	0.00	<0.01	Weak
	Aspirin use to prevent cardiovascular disease and colorectal cancer: screening	<0.01	<0.01	0.00	Strong
	Hepatitis C virus infection in adults: screening	<0.01	0.00	<0.01	Moderate
	Immunodeficiency Virus infection: screening	<0.01	0.00	<0.01	Moderate
	Folic acid for the prevention of neural tube defects: preventive medication	<0.01	<0.01	0.00	Moderate
	Abdominal aortic aneurysm: screening	<0.01	<0.01	0.00	Strong
	Pneumococcal conjugate vaccine	<0.01	0.00	<0.01	Weak
	Pneumococcal polysaccharide vaccine	<0.01	0.00	<0.01	Weak
	Zoster recombinant vaccine	<0.01	0.00	<0.01	Weak

(continued on next page)

Table 1. (continued)

		PCP only care	Team based care[a]		Strength of evidence for time estimates[b]
		PCP time (h/day)	PCP time (h/day)	Non PCP time (h/day)	
	BRCA related cancer: risk assessment	<0.01	0.00	<0.01	Moderate
	BRCA related cancer: genetic counseling	<0.01	0.00	<0.01	Moderate
	Medication use to reduce risk of breast cancer: screening	<0.01	<0.01	0.00	Moderate
	Medication use to reduce risk of breast cancer: counseling	<0.01	<0.01	0.00	Moderate
	Total time	**14.06**	**2.01**	**12.05**	
Chronic disease care[a]	Hypertension	1.72	0.86	0.86	Weak
	Anxiety disorders	1.60	0.80	0.80	Weak
	Mood disorders	1.27	0.64	0.64	Weak
	Lipid disorders	0.69	0.35	0.35	Weak
	Osteoarthritis	0.68	0.34	0.34	Weak
	Diabetes mellitus	0 50	0.25	0.25	Weak
	Asthma	0 33	0.17	0.17	Weak
	Inflammatory joint disorders	0 26	0.13	0.13	Weak
	Coronary atherosclerosis	0.11	0.06	0.06	Weak
	Other upper respiratory disorders	0.04	0.02	0.02	Weak
	Total Time	**7.20**	**3.60**	**3.60**	

Abbreviations: PCP, primary care provider; BRCA, breast cancer gene
[a]The time required for chronic disease care for team based care was assumed to be divided evenly between PCPs and non PCPs.
[b]The quality of evidence was classified as "strong," "moderate," or "weak," depending on the evidence source. Data from a meta analysis or randomized control trial was considered "strong"; evidence from cohort or case studies was considered "moderate," and data based on expert opinion or author estimates was considered "weak."

To estimate the annual visit frequency, we reviewed published guidelines (Appendix Table 4), and collected data on the number of visits required to address controlled vs uncontrolled disease.[8, 19–27] If no evidence existed, clinical authors (J.P, C.B, N.L.) independently estimated the annual visits needed, and discussed until consensus. Little data existed quantifying the time needed per visit for each chronic disease. Similar to previous analyses,[8] we assumed 10 min per visit to address each chronic disease and tested this assumption in sensitivity analyses.

Acute Care. To account for acute care, we examined nationally representative studies of primary care office visits. These studies found PCPs had approximately 637 visits per 1000 adult patients per year,[28] and a mean visit duration of approximately 21 min.[29] The time needed to address acute care for each panel was calculated by taking the product of the average number of annual acute care visits per patient, the number of patients per panel, and the mean visit duration.

Documentation and Inbox Management. We estimated this time based on evidence that PCPs spend 3.2 h per day on average on documentation, paperwork, and after visit care.[30, 31]

Team-Based Care

Preventive Care. We re-estimated the time needed to provide care when dividing time between a PCP and other care team members. We modeled estimates based on the team members in CPC+ because this advanced model allowed us to estimate times for a wide scope of disciplines.[9, 32] We determined which preventive care tasks could be done by non-PCP team members by reviewing scope of practice guidelines for each discipline, and calculated the time spent for each team member. We used national guidelines published by governing bodies for each discipline, or Illinois guidelines if national guidelines were not available.[33–36] We assumed non-PCP team members performed all services within their scope of practice instead of the PCP.[33–36]

Chronic Disease and Acute Care. Estimates for the time spent on chronic disease and acute care that could be offset by team-based care models were determined by literature review. For seven of ten chronic diseases, we found evidence non-PCP team members could perform some chronic disease management independently from the PCP,[37–43] but little data existed quantifying the time saved. We assumed 50% of PCP time could be saved for chronic disease and acute care, and examined this assumption in sensitivity analyses.

Documentation and Inbox Management. We found evidence medical assistants could screen inboxes for PCPs,[44–46] but little data existed quantifying the time saved. We assumed 20% of PCP time could be saved and examined this assumption in sensitivity analysis.

Analysis

For each of the 1000 hypothetical panels of 2500 NHANES participants, the time needed to address preventive care,

chronic disease care, acute care, and documentation/inbox management was calculated as outlined above. The means of these data were aggregated, and are displayed in our results.

Sensitivity/Scenario Analysis

We conducted additional analyses to evaluate the robustness of the results. We varied patient panel size between 1500, 2000, and 3000 patients. We also re-estimated the chronic disease visit time, assuming treating multiple concordant chronic conditions would take less time than treating each condition separately.[47, 48] We created four clusters of related conditions: "metabolic disorders" (hypertension, hyperlipidemia, diabetes, and coronary artery disease), "psychiatric disorders" (mood disorders and anxiety disorders), "respiratory disorders" (asthma and other upper respiratory disorders), and "musculoskeletal disorders" (osteoarthritis and inflammatory joint disorders). The time needed for each cluster was based on the sum of each patient's annual visits needed to address each chronic disease within the cluster, assuming that the first three visits would take 10 min each and each additional visit would take 5 min. We created a separate sensitivity analysis assuming chronic disease visits would take 5 min, instead of 10 min. Lastly, we varied the percentage of PCP time for chronic disease and acute care saved by team-based care by ±25% (75% and 25%), and for documentation/inbox management by ±10% (30% and 10%).

RESULTS

For an average 2500-patient panel, a PCP would require 26.7 h/day to provide preventive, chronic, and acute care with documentation/inbox management (Fig. 2). Preventive care alone would require about 14.1 h. Each preventive care task time varied from less than 1 s/day (medication to reduce breast cancer) to 4.1 h/day (obesity counseling) (Table 1). Over 10 h

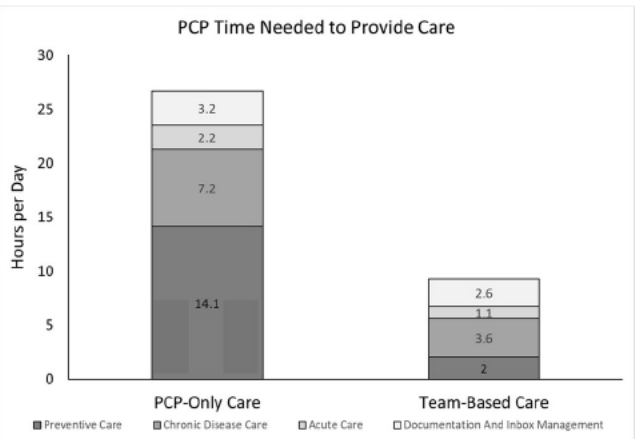
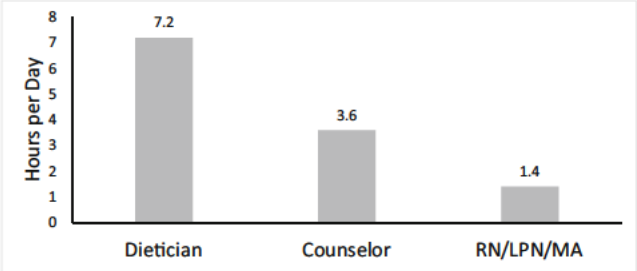


Fig. 2 Primary care provider time needed to provide care for average US adult panel of 2500 patients.



Abbreviations: RN, Registered Nurse; LPN, Licensed Practical Nurse; MA, Medical Assistant

Fig. 3 Additional preventive care time shifted to non PCP team members in a team based care model. Abbreviations: RN, registered nurse; LPN, licensed practical nurse; MA, medical assistant.

would be spent on counseling tasks, especially dietary or obesity counseling. Chronic disease care alone required about 7.2 h/day. Acute care would require 2.2 h/day, while documentation and inbox management would require 3.2 h/day.[30, 31]

With team-based care, the total PCP time decreased to about 9.3 h/day. Non-PCP team members could partially or completely perform 29 preventive care tasks, leaving about 2.0 h of preventive care tasks per day for the PCP. The majority of time reduction was due to 10.8 h of counseling tasks being transferred to dieticians or counselors. Chronic disease care would decrease to 3.6 h/day, acute care to 2.2 h/day, and documentation/inbox management to 2.6 h/day. Overall, 17.4 h could be shifted to other members of the health care team (Figs. 2 and 3).

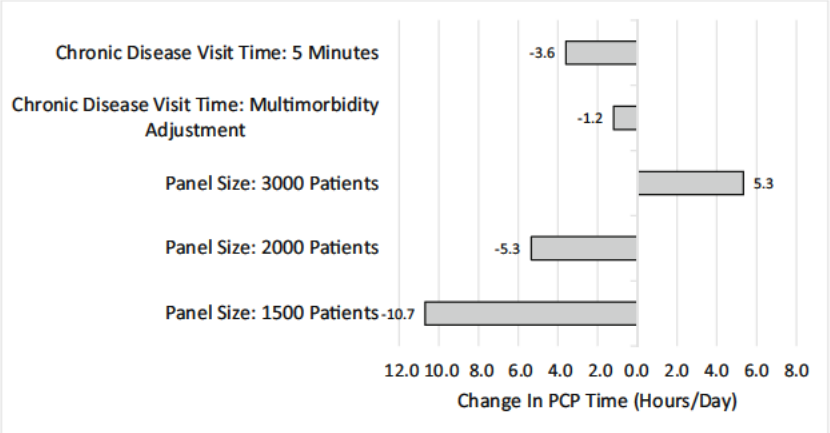
Sensitivity/Scenario Analysis

Using best-case assumptions (a 1500-patient panel, team-based care, 5 min per chronic disease visit, 75% of chronic disease/acute care time, and 30% of documentation time performed by other team members), a PCP would require 4.5 h/day. However, using the worst-case assumptions (a 3000-patient panel, no team-based care), total time increased to 32.0 h/day.

Changing the panel size to 1500, 2000, and 3000 patients resulted in −10.7, −5.3, and +5.3 h change in PCP time without team-based care, and −3.7, −1.9, and +1.9 h change with team-based care (Figs. 4 and 5). Accounting for multimorbidity by "clustering" chronic diseases decreased the PCP time by 0.6 and 1.2 h with and without team-based care, respectively. Assuming a 5-min chronic disease visit time decreased the PCP time by 1.8 h with and 3.6 h without team-based care. Assuming 25% or 75% of chronic disease care could be done by non-PCP team members resulted in a ±1.8 h change in PCP time.

DISCUSSION

Our study found that a PCP would need an infeasible 26.7 h/day to provide preventive, chronic disease, and acute care for an average US adult patient panel. If a PCP worked in a team-based care model, up to 65% of his services could be performed by other healthcare team members. Only under the



Abbreviations: PCP, primary care provider

Fig. 4 Sensitivity/scenario analyses: change in PCP time with PCP only care. Abbreviations: PCP, primary care provider.

best-case assumptions could total PCP time fit into a standard 8-h workday.

Our estimates for preventive care time (14.1 h) were higher than estimates by Yarnall et al. (7.4 h) or Privett et al. (8.6 h).[6, 7] This difference is largely explained by differences in calculating the time needed for counseling tasks. We based our estimates on USPSTF meta-analyses, which demonstrated that effective counseling interventions are extremely time intensive.[49–51] For example, obesity counseling requires "12 or more sessions" per year to provide evidence of benefit,[52] with most studies taking more time than our conservative estimate of 72 total minutes per patient per year.[50, 52] Privett estimated counseling times more conservatively. Our estimates for chronic disease care (7.2 h) were lower than Østbye et al.'s estimates, as current chronic disease guidelines recommend fewer visits per year.[20, 21]

Given the large gap between the time required to provide guideline-based care and the limits of a clinic day, many clinicians are likely not completing specific services, not completing them according to the guidelines, or working overtime. If time pressures are driving a gap between guideline-based and clinical medicine, it might explain why national health outcomes are worse than expected.[53] It may also drive physician burnout, which is often associated with large panel sizes[54] and the subjective feeling of being overworked.[4] Low income and racial/ethnic minority status are strongly associated with insufficient access to primary care.[55] To the extent that the excessive time required to provide guideline-based care is exacerbating the physician shortage, it may be contributing to unequal access to care. If clinical guidelines do not consider the time opportunity cost of an intervention, the gap between guideline-based and clinical medicine will persist.

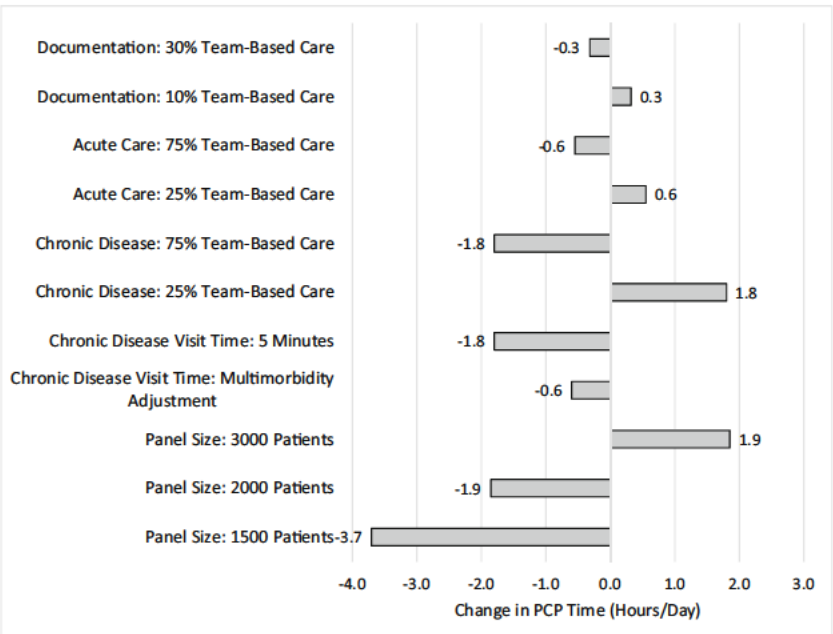


Fig. 5 Sensitivity/scenario analyses: percent change in PCP time with team based care. Abbreviations: PCP, primary care provider.

Advanced team-based care may reduce the time needed for PCPs to deliver guideline-based care. Counseling tasks are extremely time intensive,[49–51, 56] but the majority of PCP time saved occurred by shifting those tasks to other team members. Our findings support a 2012 study which concluded that non-PCPs could complete 77% of preventive care guidelines and 47% of chronic disease care.[57]

Team-based care models may save PCPs time at the expense of fragmented patient care. However, the efficiency gains from providers working at the top of their license and well-functioning team-based care models may limit this downside. Overall, team-based care models may be associated with increased adherence to quality measures at marginally lower total costs.[58]

We chose the CPC+ model as it was a functioning care model that incentivized a broad range of team-based care services. Other models in the community (and even individual CPC+ clinics) may not have access to all the team members envisioned by our idealized model. As a result, their ability to save PCP time may be more limited. Conversely, if a team-based care model included a broader range of team-members, such as dentists or physical therapists, more PCP time could be saved. Our estimates of PCP time with and without team-based care represent two polar scenarios for a PCP to provide guideline-based care, and individual results may vary.

Some innovative care models incentivize adoption of team-based care;[32, 58] however, fee-for-service healthcare reimbursement does not allow many non-PCP team members to be paid for services.[59, 60] Dietician performed dietary counseling is only reimbursed by Medicare if the patient has diabetes, renal disease, or a renal transplant,[61] though USPSTF guidelines also recommend dietary counseling for other populations. Even with a transition to value-based care, the debate of whether each potential team member adds sufficient value to be hired will remain.

The challenge of implementing team-based care models is compounded by low PCP compensation. PCPs are reimbursed at lower rates than specialists, are more likely to maintain high-volume clinics,[62] and spend large amounts of time doing uncompensated between-visit work.[63] In this setting, it would be a challenge for a PCP to handle the costs of hiring new employees without additional payment. Unless new compensation models are implemented, these team-based care models might not be feasible.

Significantly lowering the panel size to less than 1500 patients may allow time to provide guideline-based care, and the emergence of "direct primary care" models may reflect this opportunity.[54] However, the membership fees necessary to support these models may preclude their dissemination, and smaller panels would exacerbate the current PCP shortage.

Our study had several limitations. Little evidence existed on the time needed to address each chronic disease at each visit, but even assuming a 5-min visit time or accounting for time saved from clustering concordant chronic diseases did not change our conclusions. Assuming different panel sizes resulted in proportional changes to our results, but even a 1500-patient panel required 16.0 h/day of PCP time. Under every scenario our conclusion was the same: providing ideal guideline-based preventive, chronic disease, and acute care services places an unreasonable time burden on a PCP that is only partially mitigated by team-based care models and smaller panel sizes.

Our calculations represent a lower bound estimate for PCP time. We consistently chose the most conservative time estimate for which there were data, included only ten chronic diseases, limited our preventive care services to USPSTF recommendations, and did not account for breaks in time between patients. We also did not account for inefficiencies associated with combining visits for all the separate preventive care/chronic disease/acute care services into discrete clinic time slots. Additionally, the 2020 COVID-19 pandemic has at least temporarily increased the workload for PCPs, leading to large increases in electronic work which is not accounted for in this analysis.[64, 65] Finally, many common patient-specific factors and conditions requiring PCP time were not addressed. Issues such as aging/frailty, language concordance, or homelessness were indirectly addressed insofar as they are associated with a higher risk for chronic diseases, but were not accounted for independently.

Overall, it would take an infeasible 26.7 h per day for a PCP to provide guideline-based care for a 2500 patient panel in 2020. This time could be decreased to 9.3 h per day with team-based care. These findings explain why improvements in the quality of primary care have eluded the USA for the last two decades. Models of primary care that leverage and reimburse appropriately for interdisciplinary teams can only partially rectify the US healthcare system.

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Declarations:

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