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 20, 2026

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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.