**Statement for the Record**
**American College of Physicians**

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**House Energy and Commerce**
**Subcommittee on Health**

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

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Chairmen Guthrie and Griffith and Ranking Members Pallone and DeGette, on behalf of the American College of Physicians (ACP), thank you for the opportunity to testify today. My name is Dr. William Fox, and I am Chair Emeritus of the ACP Board of Regents. ACP is the nation's largest medical specialty organization, with more than 163,000 internal medicine physicians, related subspecialists, and medical students, and it is an honor to represent them at today's hearing. I am also an internal medicine physician practicing in a small, independent primary care practice in Charlottesville, Virginia.

Internal medicine physicians form the backbone of our nation's adult primary care workforce. We represent the largest cohort of practicing primary care physicians in the country, making up 41.4% of the primary care physician workforce. Our physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of

adults across the spectrum from health to complex illness. Primary care physicians provide longitudinal, cognitive care – the sustained, continuous relationship-based care that has been shown to improve health outcomes, reduce hospitalization, lower health care costs, and reduce mortality.

I would like to share more about my background and experience relevant to today's hearing. As mentioned, I am an internal medicine primary care physician in a small and still independent practice in Charlottesville, Virginia – a practice which I share with two other physicians. We have been in practice for 23 years, and during that time, we have been navigating the challenges of maintaining a viable practice in the face of significant headwinds.

When we started our practice, ours was one of many independent practices in our community. Over the years, I have watched too many of these practices be absorbed by large health care systems, be sold to private equity companies, or simply close their doors. Our practice's own capacity to accept new patients is limited at this point, and my staff relay stories of prospective patients upset and even tearful on the phone when they learn of wait times of 6 to 10 months for a new patient appointment, if at that moment we can even accept new patients at all. They simply don't know how they are going to find a doctor.

I am passionate about preserving primary care, because it is essential that we do so. It is the foundation of a highly functioning health care system. I am equally passionate about maintaining independent practice as a vital part of our country's health care infrastructure. Our patients value the very personalized, trusted, and longitudinal relationships that we provide as a

partner in their health that they may not get at larger health systems. What is more, studies consistently show that independent primary care practice is associated with lower health care spending and lower burnout rates among physicians.

For decades, our country has not been intentional in its approach to physician reimbursement and the physician workforce policies that would best serve Americans. This neglect has directly led to the erosion of both primary care and independent practice. The decline in physician reimbursement by 33% when adjusted for inflation since I started my practice is an example of one such policy neglect.

Despite these enormous challenges, I actually feel more optimistic than ever that these problems for primary care and independent practice are solvable. Recent developments, including Advanced Alternative Payment Models and Advanced Primary Care Management services codes recently created by Medicare, have helped me for the first time envision a potential pathway for success for independent primary care.

The challenges I face in keeping my independent primary care practice open to serve my patients are not unique; they are emblematic of the broader pressures threatening the viability of independent physician practices in the United States. Across the country, physician-owned independent practices are closing their doors or selling to larger health systems and private equity firms. A recently published report underscored this reality. The report analyzed physician employment and practice acquisitions from 2018 to 2026 and found that the number of independently owned physician practices has declined by over 48.5%, with approximately one-

third of physician practices in this country owned by physicians. Only 18% of working physicians still practice in independent practice settings, compared to over 48% in 2018.

The growing trend in independent practice closures is not just a workforce problem, but an access problem – made worse by the increase in health care consolidation. When primary care physicians can no longer keep their practices open, patients lose something irreplaceable – a trusted physician who knew them and their families. Often, patients find themselves struggling to navigate their new reality – seeking care in corporate systems, where care is often influenced by what is profitable rather than what is best for them. They are left with fewer choices, longer wait times, and less time with their physicians. ACP remains concerned with the impact of health care consolidation, specifically with private equity acquisitions, on patients' access to high-quality physician-led care and the physician workforce. The data show high physician turnover rates after private equity acquisitions of independent practices. This has led to patients being forced to switch physicians, disrupting care and resulting in higher costs and poorer clinical outcomes.

The decline in the number of independent physician practices can be attributed to several factors, including but not limited to the instability of payments in the Medicare Physician Fee Schedule (MPFS), onerous quality metric requirements in the Medicare Access and CHIP Reauthorization Act's Quality Payment Program (QPP), as well as the excessive and often unnecessary administrative paperwork for prior authorizations forced on physicians by health insurers. The factors that threaten the viability of independent physician practices are inseparable from the access challenges facing our patients and your constituents. When physicians cannot sustain their independent practices, patients cannot seek the care that they need, when they need it. A

declining physician workforce produces a health care system in crisis. Congress cannot address one without addressing the other.

Today, I am grateful for your leadership and bipartisanship in working together to improve the structure of Medicare for the betterment of our country's seniors and the physicians serving them. In addition to my own experiences, I am pleased to share with you ACP's policy recommendations on how to improve seniors' access to high-quality health care and provide physicians with long-term payment relief through reforms in the MPFS, as well as the Medicare Access and CHIP Reauthorization Act (MACRA), specifically with respect to Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS).

**ACP's Recommendations to Improve the MPFS**

There is a critical need for Congress to reform Medicare physician payment. The current structure of the MPFS does not provide sustainable, reliable, and consistent payment rates for physicians who see Medicare beneficiaries. Notably, the MPFS is one of the only fee schedules left that does not have annual inflationary updates. As I noted earlier, when accounting for inflation, Medicare physician payments have declined by a staggering 33 percent since 2001. While physician services represent a very modest portion of the overall growth in health care costs, they are unfortunately primary targets for cuts when policymakers seek to tackle spending. **ACP has long advocated for legislation to ensure Medicare payments to physicians keep up with inflation. We continue to support the Strengthening Medicare for Patients and Providers Act, H.R. 6160, which would base future annual updates to the MPFS on the Medicare Economic Index (MEI).**

ACP is grateful for a bipartisan effort in Congress, spearheaded by Republican and Democratic physicians, to explore meaningful policies to tackle the challenges that physicians face in the MPFS. We greatly appreciate their bipartisan collaboration and urge this Committee to bring the final bill forward for consideration, once it is introduced. Furthermore, we offer the following recommendations to strengthen and preserve the MPFS.

- **Address Budget Neutrality Threshold, Inflationary Updates, and Practice Expense Updates.** The lack of inflationary updates in the MPFS, coupled with budget neutrality constraints, has led physicians to continuously struggle to keep up with practice expenses and rising inflation. This has made it much harder for physician practices to manage sharp increases in practice expenses or navigate staffing and supply shortages. Physicians routinely face harmful payment cuts, making it increasingly difficult to remain in practice and accept Medicare patients. **ACP supports the Provider Reimbursement Stability Act of 2026, H.R. 8163, which would help strengthen and stabilize the Medicare payment system by reducing the annual payment cuts in the fee schedule due to the budget neutrality mandate.** It would increase the threshold for the enactment of budget neutrality cuts from $20 million to $54.3 million and use cumulative increases in the MEI to update the threshold every five years afterwards. **ACP also supports legislation that would require the Centers for Medicare and Medicaid Services (CMS) to update the direct costs associated with practice expenses (clinical labor, the prices of equipment, and the prices of medical supplies) simultaneously at least once every five years.**

- **Reconcile utilization misestimates.** ACP remains concerned with the overestimation of new or updated codes in the MPFS. Due to the budget neutrality rule, any new codes or updated codes implemented by CMS that would put spending over $20 million in the MPFS must be offset by across-the-board cuts to other codes, no matter how badly the change is needed to improve patients' access to care. The result is that the amount withheld from the fee schedule due to budget neutrality could exceed the amount needed if the estimate is above the actual code utilization. Unfortunately, the difference in estimated usage versus actual usage does not get returned to the fee schedule, leading to additional, unnecessary physician payment cuts.

  The most prominent example of CMS overestimating utilization assumptions related to code revaluations occurred when transitional care management (TCM) services were added to the MPFS in 2013. CMS estimated 5.6 million new claims would be submitted for these services. Actual utilization, however, turned out to be just under 300,000 claims for the first year and it was still less than one million claims total after three years. As a result of just this overestimation for TCM services alone, Medicare physician payments were reduced by more than $5.2 billion from 2013 to 2021.

  While we are grateful that the Fiscal Year 2026 Labor-HHS-Education Committee Reports (House and Senate) included report language for the Government Accountability Office to conduct a 10-year look-back study and report back to Congress on the utilization estimates and actual payments incurred from the implementation of new and updated Medicare codes, we believe that more can be done to make physicians whole.

**We urge Congress to introduce and pass legislation that would return savings from the overestimation of new codes in the MPFS back into the MPFS.**

- **Prioritize investments in primary care.** Despite empirical data showing the benefits of having access to primary care physicians, the reality is that across the country, more primary care physicians are leaving the workforce at an unprecedented rate, and there are not enough medical school graduates going into primary care to make up the difference. The United States faces a projected shortage of up to 141,160 physicians by 2038 – including a shortage of over 70,000 primary care physicians. Recent survey data underscores the impact of the primary care physician shortage on patients' access to care, with long wait times averaging 31 days for patients to get an appointment with a primary care physician now.

  To preserve patient access to physician-led primary care, sufficient and sustained increases in MPFS payments for services are needed. Raising the absolute and relative compensation of general internal medicine physicians and other primary care physicians will help maintain their practice viability. A 2021 report by the National Academy of Sciences, Engineering, and Medicine, calls on policymakers to increase our investment in primary care as evidence shows that it is critical for "achieving health care's quadruple aim (enhancing patient experience, improving population, reducing costs, and improving the health care team experience)." The report urges the need to reform a Medicare physician payment system that not only undervalues primary and cognitively focused

care but also does not adequately incentivize the type of high-quality, value-based care that patients need.

In ACP's policy position paper, *Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms*, we recommend that all payment systems substantially increase relative and absolute payments for primary care commensurate with its value in achieving better outcomes and lower costs. Inappropriate disparities in payment levels between complex cognitive care and preventive services, relative to procedurally-oriented services, should be eliminated. It is essential that payment policies recognize the value of primary care and that payment is sufficient to reverse the primary care physician shortage.

**Stabilizing the primary care physician shortage requires targeted investments in the MPFS, outside the zero-sum constraints of budget neutrality.**

- ACP recommends that any investment should be structured in a practical and meaningful way. ***One example is the Primary Care Incentive Payment Program (PCIP) that expired in 2015.*** This approach would reduce administrative complexity while ensuring that payments are targeted toward physicians whose practices are primarily devoted to longitudinal primary care. Additionally, and importantly, payments should be tied to the individual clinicians' National Provider Identifier (NPI) to ensure that payments are directly tied to the individuals providing primary care services. This is especially important as the majority of physicians are now employed and no longer in independent medical practices.

- ***The implementation of the Advanced Primary Care Management (APCM) services codes is a meaningful step in the right direction for further investments in primary care.*** However, APCM services are still subject to budget neutrality constraints and are not considered preventive services, which subjects patients to Medicare cost-sharing and creates a barrier to enrollment. ACP supports efforts to waive cost-sharing for APCM services. Additionally, while independent practices like mine have seen significant potential in using APCM services codes, smaller independent practices may face barriers to participation if they are not part of an Accountable Care Organization (ACO) or other APM arrangements. We urge Congress to allow physicians to bill APCM services independent of ACO and APM participation requirements, similar to Chronic Care Management (CCM) services. This would ensure more participation from small, rural, independent primary care practices without the resources to participate in ACOs or APMs.

**ACP's Positions on the 2026 Physician Fee Schedule Final Rule**

The College is supportive of several policy changes in the 2026 Physician Fee Schedule Final Rule that will help to better support the primary and comprehensive health care provided by primary care physicians.

- **ACP supports the efficiency adjustment as implemented by CMS, as it will help ensure that payment for non-time-based services, which have been historically overvalued, reflects the actual cost and time it takes to deliver them by taking into consideration the increased efficiency clinicians have gained over time.** These

efficiencies are achieved through technological advancements, practice improvements, and standardized workflows that are currently not captured by the payment valuation system. This approach improves valuation accuracy across the fee schedule while helping address the longstanding undervaluation of cognitive and longitudinal care. We have written to CMS to urge it to refine this approach through future rulemaking and ongoing collaboration with interested parties. Specifically, we recommended applying the proposed efficiency adjustment in 2026, followed by a reassessment to allow the health care community an opportunity to address future adjustments in a data-driven manner, rather than applying it automatically every three years.

- **ACP is also supportive of the updates to the practice expense (PE) determination methodology to better recognize indirect costs for physicians in office-based settings.** This adjustment helps address long-standing overvaluations in the fee schedule that have disproportionately negatively affected primary care and independent practices. Shifting resources toward more accurate reimbursement levels is a step in the right direction to support practice sustainability and health system equity. Looking ahead, CMS must work collaboratively with stakeholders, including specialty societies and independent practice representatives, to ensure future PE refinements are transparent, data-driven, and designed to avoid unintended consequences.

**ACP's MACRA Recommendations**

ACP urges the Committee to support legislation that would ensure that MACRA fulfills its goals as intended to transform Medicare physician payment from a fee-for-service (FFS) model that

pays physicians based on the number of services provided to a value-based model that incentivizes the quality and outcome of care delivered to patients. The College has been a consistent and constructive voice in the implementation of MACRA. We are concerned that since its passage in 2015, MACRA has fallen short of truly shifting payments away from an FFS model or moving the needle toward achieving greater equity in the delivery of health care. In 2022, ACP provided comments in response to a Congressional Request for Information (RFI) on recommendations to improve MACRA, where we shared a series of reforms to improve the MIPS and APM programs in MACRA.

Our comments underscored our support for MACRA, as it instituted creative policies under the QPP, a payment system that rewards physicians based on the quality and value of services provided to patients. Physicians participate in the QPP under one of two payment tracks: the MIPS or APMs. MACRA intended to provide strong incentives for physicians to engage in activities to improve quality; streamline existing quality reporting programs to reduce administrative burdens; and provide additional support to physicians who participate in APMs shown to improve outcomes and the effectiveness of care provided. Unfortunately, our physicians have not achieved these goals in MACRA, as this payment system has failed to provide:

- Positive, consistent, and stable annual payment updates that offer the financial stability needed for our physicians to transition their practice to value-based payment models;
- Meaningful and actionable quality reporting initiatives that adequately measure the quality of care our physicians provide to their patients;

- A sufficient number of Advanced APMs (AAPMs) for our physicians to join to provide high-quality value-based care to their patients.

**ACP Recommendations to Improve MIPS**

ACP remains committed to a payment system that rewards quality and value of care. However, after nearly a decade into MIPS' implementation, we must be candid with the Committee: MIPS, as currently structured, is not achieving its intended goals for many primary care physicians, particularly those in small and independent practices. Meaningful reform is long overdue for the program.

**Address administrative burden**

Administrative burden associated with MIPS reporting has become unsustainable. While it was designed to reward physicians for the quality of care they provide, it has become overly focused on administrative compliance rather than meaningful quality improvement. The reporting requirements, across four performance categories, include changing measure sets and annual rule changes, requiring significant time commitment and resources that an overstretched primary care physician workforce does not have. The program requires primary care physicians to report on dated and inappropriate quality metrics. For example, ACP has documented that a majority of MIPS quality measures in ambulatory internal medicine are not valid, as they are not meaningfully linked to patient outcomes. MIPS quality measures need to be more relevant, accurate, and effective, with a focus on patient outcome measures.

- Congress should weigh in with CMS to reduce the number of measures required for full participation in the quality category of MIPS.

- Congress should exercise congressional oversight: CMS must simplify the scoring structure and reporting requirements under MIPS to fulfill the Congressional intent of a more streamlined program that reduces burdens on physicians.

**Raise the low-volume threshold and restructure the penalty cliff**

Many small and independent practices, especially those in rural and underserved areas, fall just above MIPS' current low-volume threshold (billing more than $90,000 to Medicare Part B, seeing 200 or more Medicare patients, and furnishing more than 200 professional services per year). These practices are under-resourced, and yet they must comply with MIPS' reporting requirements without the billing infrastructure, staff, or revenue to support their participation. Additionally, the current payment adjustment of 9%, tied to a 75-point performance threshold, creates a punitive cliff rather than a meaningful incentive structure. Physicians who are one measure away from the threshold could face significant monetary penalties not connected to the quality of care that they provide.

- Congress should direct CMS to meaningfully raise the low-volume threshold to reflect the actual burden MIPS imposes on small and independent physician practices
- Congress should restructure the adjustment range to be more gradual, ensuring that the penalty exposure does not significantly impact small and independent physician practices

**ACP supports the Medicare Physician Data-Drive Performance Payment System Act of 2026, introduced by Drs. Mariannette Miller-Meeks and Herb Conaway.** This critical

legislation seeks to modernize Medicare payments by reducing administrative burdens, improving patient care, and supporting small/rural practices through a more practical, data-driven approach. It would replace MIPS with a system designed to improve fairness, transparency, and clinical relevance while reducing unnecessary administrative burden. As noted earlier, MIPS has disproportionately penalized small and rural practices. It has increased the administrative burden of compliance on those practices as well, while not effectively measuring quality and leading to more health inequities. The legislation reforms include:

- Reducing excessive penalties and creating a more balanced payment structure;
- Reinvesting funds into quality improvement and support for under-resourced practices;
- Providing quarterly performance feedback so physicians can make real-time improvements;
- Increasing transparency in cost attribution to support better clinical decision-making; and,
- Protecting physicians from penalties when sufficient performance data is not provided.

**Recommendations to Improve Advanced APMs (AAPMs)**

ACP believes that well-designed APMs represent the most promising path toward a Medicare payment system that could truly reward value and quality of care rather than volume of services delivered. However, there are several obstacles that stand in the way of physicians participating in APMs. ACP published two policy papers, our *New Vision for Health Care Delivery and Payment System Reforms* and *Reforming the Physician Payment System to Achieve Greater Equity and Value in Health Care*, that provide our specific recommendations to reform APMs. In our response to the RFI on MACRA, we urged Congress and CMS to enact several reforms to

ensure additional opportunities for our physicians to participate in APMs. For this hearing, I would like to emphasize two ACP's policy priorities that Congress can take to ensure increased participation in AAPMs.

**Extend the five percent APM participation incentive and halt the revenue threshold increase for five years**. MACRA's five percent AAPM bonus was one of the most important policy levers that encouraged physicians to take on risks and move away from an FFS model. That incentive has since expired, and while we are grateful for Congressional action to provide short-term fixes, physicians need long-term payment predictability if they are expected to take on downside financial risks as they transition to a value-based model.

**ACP supports the Value in Health Care Act, introduced in the 118th Congress, as it would extend the five percent bonus for physician participation in AAPMs.** The bill would also give the CMS the authority to adjust AAPM qualifying thresholds so that the current one size-fits-all approach does not serve as a disincentive to including rural, underserved, primary care or specialty practices in AAPMs. This approach would help to maintain incentives that support physicians' transition from a volume-based FFS health care system to one that is based on the value and quality outcomes of health care delivered to the patient.

**Reduce the current two-year lag between each performance year and the subsequent payment year.** The two-year lag between AAPM performance and payment is a fundamental design flaw that undermines and limits participation in AAPMs. A small,

independent practice cannot wait two years for incentives on an investment it made today. Further, for those who take on the risks, they are subject to rule changes mid-cycle, leaving them without financial support to unwind practice investments if their incentives erode due to rule changes.

- Congress should direct CMS to shorten the qualifying participant determination-to-payment lag time
- Congress should require that any changes to AAPM incentive structures take effect no sooner than two performance cycles out, giving physicians sufficient notice before deciding to participate in AAPMs

**Additional Recommendations to Support the Physician Workforce**

As the Committee examines policies to support physicians, ACP would like to underscore two issues that have imposed considerable strain on the primary care physician workforce. ACP strongly urges the Committee to tackle overly burdensome administrative tasks faced by physicians and their patients with prior authorizations, as well as the growing trend that health insurers are using to downcode Evaluation & Management (E/M) services.

**Pass Prior Authorization Legislation**. Prior authorization remains one of the most burdensome, unnecessary administrative tasks our physician members must deal with every day. It involves paperwork and phone calls, as well as varying data elements and submission mechanisms that force physicians to enter unnecessary data in electronic health records (EHRs) or perform duplicative tasks outside of the clinical workflow. This inhibits clinical decision-making at the point of care, creating a barrier to medical care for patients. Moreover, prior authorization can

contribute significantly to the burnout epidemic among physicians. A survey of more than 600 medical groups in March 2023 showed that 84 percent reported an increase in their prior authorization requirements for Medicare Advantage (MA) plans. In 2022, a survey of more than 500 doctors from group practices found that 89 percent believe that regulatory burdens increased in the past year, and 82 percent responded that the prior authorization process is very or extremely burdensome.

ACP has strongly been in favor of standardizing and streamlining prior authorization processes over the years. In a policy paper, *Putting Patients First by Reducing Administrative Tasks in Health Care*, ACP advocated that, "Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved. Payers, public and private oversight entities, and vendors and suppliers must work together and actively engage with clinician societies and frontline clinicians to harmonize their administrative policies, procedures, processes, and forms regarding such issues as prior authorizations, payment reviews, reporting requirements, and others." **The College has repeatedly voiced support for the Improving Seniors' Timely Access to Care Act, first introduced in 2019, which would protect patients from unnecessary delays in care and reduce administrative burden on physicians by streamlining the prior authorization approval processes in Medicare Advantage. We urge this Committee to pass this critical legislation.**

**Stop commercial payers from downcoding E/M codes.** There is a growing and troubling trend being used by commercial health payers regarding the algorithmic downcoding of E/M services.

When CMS updated the E/M coding guidelines in 2021 for office and outpatient visits, it was meant to be a step forward for primary care. One that is better reflective of the true complexity of providing longitudinal, cognitive care, while reducing administrative burden on physicians. However, those reforms are being systematically circumvented by commercial payers. Commercial insurers are now using artificial intelligence (AI) to automatically reduce the level and payment of E/M claims. They are doing this without taking into consideration patients' medical records and often without notifying physicians before making adjustments. What this means in reality is that physicians who see patients with multiple chronic conditions, who document complex visits, and bill accordingly under nationally recognized coding standards, are not being reimbursed appropriately for their work. This is a payment integrity problem that is disproportionately impacting independent primary care physicians who are already operating on the thinnest margins in our health system.

**We urge the Committee to examine this troubling trend and to act to ensure that at a minimum, health insurers cannot downcode any E/M claims without first conducting actual clinical record reviews. Further, physicians should be given advance notice when their claims are subject to an AI downcoding program and should receive a written rationale when claims are adjusted to a lower level. Moreover, there should be significant financial consequences for commercial payers who intentionally use AI to systematically suppress payment for care that was documented, delivered, and billed appropriately. Any financial penalties collected through this effort should be reinvested directly into longitudinal, cognitive care.**

**Conclusion**

ACP would again like to sincerely thank Chairmen Guthrie and Griffith and Ranking Members Pallone and DeGette for convening this hearing and for your continued desire to see that the value-based system, as established under MACRA, is achieving its goals as intended by Congress. We in the physician community appreciate this opportunity to offer our recommendations to further transition our health care system to one that rewards value and quality. We very much want to be part of this process and provide feedback whenever needed. Thank you for your consideration.