



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.<sup>1</sup> 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.<sup>2</sup> 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

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<sup>1</sup> 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>.

<sup>2</sup> 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.<sup>3</sup> “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.

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<sup>3</sup> 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](mailto:jhaynes@mgma.org) or 202-293-3450.

Sincerely,

/s/

Anders Gilberg  
Senior Vice President, Government Affairs