September 15, 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 Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity"

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 Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity." Numerous pieces of legislation being considered by the Subcommittee today would help create long-term stabilization for the Medicare reimbursement system that has threatened the livelihood of our nation's medical practices for years.

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 appreciate the Subcommittee for discussing legislation that would address fundamental flaws with the current Medicare payment system. We offer the following recommendations on specific bills before the Subcommittee today.

Patients First Act of 2026

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. Physician practices have been warning for years about reimbursement failing to keep up with costs and its impact on current and future Medicare patient access. Eighty percent of medical practices report Medicare payment rates do not cover the cost of care in 2026, while 84 percent of medical groups report increased operating costs.[1]

Practices detail having to consider limiting the number of new Medicare patients, reducing charity care, reducing the number of clinical staff, and closing satellite locations should Medicare payment continue on this track.[2] The proposed 2027 Medicare Physician Fee Schedule includes another cut to physician reimbursement that amplifies these concerns and further pushes independent practices closer to selling to larger entities or shutting their doors. In addition to failing to cover the cost of providing care to Medicare beneficiaries, due to the centrality of Medicare rates to benchmarks for commercial payers and Medicaid, inadequate Medicare reimbursement has cascading effects across payers.

Given the downward trajectory of Medicare reimbursement, with its frequent reductions and lack of an inflationary update, it is time to stop the significant negative impact of inadequate reimbursement. The Republican and Democratic Doctors Caucuses worked together to introduce the Patients First Act, a comprehensive, bipartisan legislative package that addresses core Medicare payment concerns by:

- Tying Medicare reimbursement to the Medicare Economic Index (MEI): creates predictable, annual increases in Medicare reimbursement.
- Reforming the Merit-based Incentive Payment System (MIPS): introduces the POINTS program that would create the Quality Reform Task Force, reduce MIPS payment penalties, and more.
- Extending Advanced Alternative Payment Model (APM) policies: freezes qualifying APM participant (QP) thresholds and includes new requirements for the CMS Innovation Center (CMMI) models.
- Modernizing antiquated budget neutrality requirements: includes the Provider Reimbursement Stability Act.

We urge the Subcommittee to pass the Patients First Act as a comprehensive package to avoid a series of patchwork policies and enact structural reform.

Provider Reimbursement Stability Act

The Provider Reimbursement Stability Act (H.R. 8163) would make necessary modernizing changes to Medicare's budget neutrality rules that have triggered widespread cuts to physician reimbursement. These broad cuts to Medicare reimbursement are required by statute to offset changes in Relative Value Units (RVUs) over a low threshold that hasn't been updated in decades. For example, important increases to office visit RVUs often result in reimbursement cuts to unrelated procedures. Compounding the negative effects of this low threshold is the fact that erroneous utilization estimates by CMS often lead to these

[1] MGMA Stat, Operating Costs Keep Climbing for Medical Practices in 2026, https://www.mgma.com/mgma-stat/operating-costs-keep-climbing-for-medical-practices-in-2026; MGMA Stat, 2026 Medicare Reimbursement Changes: Tracking What Matters, https://www.mgma.com/mgma-stat/2026-medicare-reimbursement-changes.
[2] *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.

cuts, yet there is no mechanism in place to correct these errors that undermine the financial stability medical groups. A recent example is CMS' erroneous utilization estimates of HCPCS complexity add-on code G2211 led to significant cuts to Medicare reimbursement. Even after actual utilization data was published and showed significantly lower uptake of the code than CMS predicted, there is no mechanism to return the $1 billion cut back into the Medicare Physician Fee Schedule.

These rules have destabilized Medicare payment over the years and undermined the ability of medical groups to continue treating Medicare beneficiaries. This bill would make necessary changes such as increasing the budget neutrality threshold and indexing it to inflation. It would also allow for the correction of erroneous utilization estimates of Medicare services to avoid unwarranted cuts. We appreciate the Subcommittee for reviewing this important bill and look forward to working with Congress to pass this critical piece of legislation as part of the Patients First Act discussed above.

Medicare Physician Data-driven Performance Payment System Act of 2026

MACRA replaced the sustainable growth rate formula with the QPP that included two reporting pathways to facilitate the transition to value-based care: MIPS and Advanced APMs. MIPS has been plagued with issues as complying with the program is a time-consuming and laborious process. 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 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. Unfortunately, this aligns with what MGMA members have 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.

The Medicare Physician Data-driven Performance Payment System Act of 2026 (H.R. 8622) 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. We appreciate the Subcommittee for reviewing this bill and look forward to working with Congress to ensure the MIPS reform measures included in the Patients First Act address the concerns of medical practices.

Conclusion

MGMA sincerely appreciates your attention to reforming Medicare payment. We urge you to pass the above-referenced legislation to remedy years of under-reimbursement and administrative burden, and reinforce group practices' ability to provide high-quality, cost-effective care. If you have any questions,

[3] MGMA's 2026 Regulatory Burden Report, Apr. 9, 2026, https://www.mgma.com/federal-policy-resources/april-9-2026-regulatory-burden-report.

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