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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).