

October 19, 2026

Amol S. Navathe, MD, PhD
Chair
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Re: AMA Comments on October 2026 MedPAC Meeting

Dear Chair Navathe:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the Medicare Payment Advisory Commission's (MedPAC) discussion of a variety of important topics at its October 2026 public meeting, including the adequacy of Medicare Advantage provider networks, issues impacting Medicare payment adequacy, and Medicare pay for performance programs, among other things. As the Commission continues its work in each of these areas, culminating in its 2027 June report to Congress, we wanted to share some of the AMA's ongoing work to advance meaningful policy changes in each of these areas.

Medicare Advantage (MA) Provider Networks

The AMA appreciates MedPAC's ongoing examination of MA provider networks, including its recent comparison of provider directories with encounter data. As MedPAC acknowledged, the finding that 32 percent of encounters involved physicians absent from enrollees' plan directories could reflect either inaccurate directory listings or out-of-network care. The AMA encourages MedPAC to continue to investigate the underlying causes of these discrepancies, as each has distinct implications for enrollees and the Centers for Medicare & Medicaid Services (CMS) oversight. Inaccurate listings raise concerns about the reliability of provider directories, while out-of-network encounters warrant further examination to determine whether plans authorized such care because their networks lacked sufficient providers to meet enrollees' needs. In cases where inadequate network access prompted plans to authorize out-of-network care, MedPAC should examine claims and enrollee cost-sharing records to assess compliance with applicable cost-sharing protections and the overall financial impact on enrollees.

The AMA also encourages MedPAC to examine effective provider availability, an important dimension of access to care that captures whether providers listed in an MA plan's network can be reached, practice at their listed locations, are accepting new Medicare patients, and offer appointments within reasonable timeframes. Building on its 2024 analysis of MA provider networks, MedPAC could evaluate how new and existing data sources—including the National Plan and Provider Enumeration System, the Provider Enrollment, Chain, and Ownership System, plan contracting records, provider directory submissions, and claims and encounter data—can be combined with independent provider outreach or secret-shopper audits to develop a reliable measure of effective provider availability. This work could help strengthen CMS

oversight of network adequacy and give prospective enrollees a clearer, more accurate picture of access to care under each plan.

Global Surgical Services

The AMA shares the Commission's interest in accurate payment for physician services, including global surgical services, and welcomes the opportunity to work with MedPAC and staff to better understand how post-operative care is delivered today. We agree that valuation must keep pace with changes in clinical practice. However, we strongly disagree with the conclusion that post-operative visits currently included in 10- and 90-day global periods are not being furnished. That conclusion rests largely on Current Procedural Terminology (CPT) code 99024 reporting data, which analyses from RAND and the Office of Inspector General (OIG) have shown to be incomplete and unreliable. This is for several reasons, most notably that the data were collected through a no-pay code required only of larger practices in nine states, and that OIG found many of the small subset of practitioners required to report the code were unaware of the requirement or lacked billing systems capable of reporting the code. Additionally, these reports rely on old information and do not reflect recent improvements to the visit data within global surgical services.

The AMA/Specialty Society RVS Update Committee (RUC) process is designed to weigh the best available evidence code by code, including physician surveys, claims data, length of stay analyses, specialty registries, and other extant data, where available. The RUC process has repeatedly reduced post-operative visits where the evidence showed that care had changed. For example, the RUC removed or reduced post-operative visits for cataract surgery and hip, knee, and shoulder arthroplasty. These post-operative visits in the 2027 valuation are consistent with the number of visits reported by the OIG. Upon reviewing the OIG reports, the RUC also recommended converting high-volume lesion destruction codes to 0-day global periods, which are to be implemented in the 2028 Medicare Physician Payment Schedule. The RUC also continues to pursue new data sources to supplement physician surveys, and we would welcome the Commission's partnership in this effort. Lastly, RUC recommendations are advisory; CMS retains final authority over every valuation, subject to public notice and comment. For a fuller discussion, we refer the Commission to pages 14 through 18 of the AMA's [comment letter](#) to CMS on the CY 2027 Medicare Physician Fee Schedule proposed rule. The RUC's review of the OIG report and follow-up discussion leading to the January 2027 re-review of destruction of lesions is available on pages 170-171 of the RUC January 2026 [minutes](#).

Incident-to Billing

The AMA does not support changes to Medicare's existing incident-to billing policy. Incident-to billing supports physician-led, team-based care, in which the physician sees the patient, initiates the course of treatment, and remains actively involved in managing it while non-physician practitioners and clinical staff furnish follow-up services in line with that care plan. Eliminating or restricting incident-to billing would disrupt how many practices organize care and could reduce patient access to timely follow-up services.

Telehealth

The AMA strongly supports permanently lifting restrictions on Medicare telehealth services so that they continue to be available to Medicare patients in all areas of the country, in patients' homes, and via audio-only or audio-video communications technology. Since 2025, separate CPT codes have been available for reporting telehealth visits, but Medicare does not recognize them for payment. The AMA has [recommended](#) that CMS add the separate telemedicine codes to the Medicare Telehealth List. CMS does

publish RUC-recommended relative values for these codes which, if used for Medicare payment, would allow more precise valuation of direct practice expenses for telehealth relative to in-person visits.

Medicare telehealth services have improved care continuity and access for rural and underserved communities, but repeated temporary extensions are disruptive and create uncertainty for patients and physicians. An AMA issue brief, “The case for permanent telehealth policy and expanded access to virtual care,” advocates for evaluating the value of telehealth by factoring in long-term savings generated by early intervention, improved chronic disease management, and reduced use of emergency and inpatient services. Evidence cited in the issue brief demonstrates that telehealth can be an effective substitute for in-person care, driving significant systemic efficiencies that traditional cost estimates miss.

Medicare CLFS

The AMA does not support additional reductions to the Clinical Laboratory Fee Schedule (CLFS). Clinical laboratory services account for less than one percent of Medicare spending but inform 70 percent of clinical decisions. Since the Protecting Access to Medicare Act of 2014 took effect, CLFS rates have been based on private payer data that did not reflect the full laboratory market, particularly hospital outreach and physician office laboratories. That flawed data cut nearly \$4 billion from the CLFS in the first three years alone. Under CMS’ preliminary CY 2027 rates, 775 tests face the maximum 15 percent cut on January 1, 2027, with further reductions scheduled for 2028 and 2029.

Rather than additional cuts, the AMA supports permanent reform of the CLFS rate-setting process through the bipartisan Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act (S. 2761/H.R.5269). The RESULTS Act would base rates on current, representative commercial data, reduce data reporting burden on laboratories and CMS, and provide payment stability that supports diagnostic innovation. For a more complete discussion, we refer the Commission to the October 30, 2025, letter to congressional leadership supporting the RESULTS Act, which the AMA joined along with dozens of other national laboratory, physician, hospital, and patient organizations.

Quality Incentives in Fee for Service Medicare

The AMA agrees with MedPAC that the CMS Merit-Based Incentive Payment System (MIPS) program is broken. It has imposed substantial reporting burdens and steep penalties—falling hardest on small, rural, and independent practices—without demonstrable improvements in quality of care. However, there is a false belief that decreasing the number of measures and MIPS Value Pathways (MVPs) will minimize burden. The number of measures or MVPs is not what drives physician burden. The real problem is poorly designed programs and their morass of reporting requirements. Many individual metrics are also flawed and fail to track clinically relevant outcomes for specific health conditions, episodes of care, and major procedures. This is particularly true for certain subspecialists.

Accordingly, the AMA, along with all 50 state medical associations, support the Patients First Act (H.R. 9693), and more specifically Title II, which replaces MIPS with a new system called the Patient Outcome Improvement National Tabulation System (POINTS). POINTS is a streamlined, clinician-driven quality program that through a new Quality Reform Task Force, will ensure CMS, clinical experts, and other relevant stakeholders work collaboratively to review measures for clinical relevance and appropriate benchmark and scoring policies. The bill also reduces penalties while creating a separate bonus performance program to reinvest in independent and small practices, mandates timely quarterly feedback reports so physicians can track and improve their performance and requires that new metrics are able to be submitted through Electronic Health Record technology, administrative or billing claims, or through a data registry to reduce clinician reporting burden. Together, these reforms will allow physicians to devote

more time to patient care and less to arbitrary reporting requirements. The comprehensive, bipartisan bill also includes critical Medicare physician payment reforms that the AMA has long advocated for, including an inflation-based payment update and budget neutrality reforms, as well as Alternative Payment Model reforms.

Medicare Late Enrollment Penalties

As the AMA noted in comments on MedPAC's March 2026 meeting, we appreciate the discussion of the complexity of Medicare enrollment decisions and the lack of information provided to people approaching age 65 about late enrollment penalties. We are also grateful for the chapter on this topic in MedPAC's June 2027 report. To help improve initial enrollment decisions, the AMA recently proposed a new model to the Center for Medicare and Medicaid Innovation that would test whether educating people approaching the age of Medicare eligibility about key aspects of Medicare affecting their enrollment decisions, timing, and choices between traditional Medicare and MA can improve care quality while reducing spending.

The AMA is also concerned that people switching from traditional Medicare to MA do not have adequate opportunities to change their enrollment if the plan does not end up meeting their healthcare needs and/or financial circumstances due to network limitations, prior authorization policies, or out of pocket costs. People who have Medigap can use a Special Enrollment Period (SEP) to return to traditional Medicare within 12 months of their MA enrollment, but this does not extend to people who do not have Medigap. We have recommended that beneficiaries who do not have Medigap when they switch to MA also have access to an SEP if they need to return to traditional Medicare within 12 months of their MA enrollment. We would appreciate MedPAC's support for both AMA policy recommendations described above.

Conclusion

Thank you for your attention to each of these critical issues. We welcome further opportunities to collaborate with the Commission as it continues this important work. Please reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org if you have questions or need further information.

Sincerely,

A handwritten signature in black ink, appearing to read 'John Whyte', with a stylized flourish at the end.

John Whyte, MD, MPH