AMGA
Advancing High Performance Health

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

Dear Dr. Navathe,

On behalf of AMGA, I appreciate the opportunity to offer our support of the Medicare Payment Advisory Commission (MedPAC) and provide insights on the critical issue of long-term sustainability of Medicare financing and the need for greater urgency regarding the growth of Part B spending highlighted in the September 3, 2026, MedPAC Public Meeting.

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. There are over 188,000 physicians practicing in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in high-value care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

Ensuring Long-term Sustainability

AMGA shares the Commission's interest in ensuring the long-term sustainability of the Medicare program. We remain concerned that without significant changes to Medicare Part B reimbursement methodologies, continued payment inadequacy will compound and erode the system's capacity to provide access to high-quality care. As MedPAC considers the growth of Medicare Part B spending, AMGA urges the Commission to modernize Medicare payment. MedPAC should distinguish between the adequacy of reimbursement for individual clinical services and increases in aggregate spending. Aggregate spending may reflect a range of factors—such as the growth in the number of Medicare beneficiaries—that do not necessarily indicate that payment rates for individual services are excessive or adequate.

As MedPAC has acknowledged, although payment updates have not kept pace with growth in clinicians' input costs, the volume and intensity of clinician services have increased substantially over time, resulting in higher Physician Fee Schedule (PFS) spending. MedPAC's own data show that recent Part B spending growth has been driven by increases in service volume and mix, rather than by payment rates. Specifically, clinician services furnished per fee-for-service (FFS) beneficiary increased by 7.1% from 2023 to 2024, compared with an average annual growth rate of 2.3% for clinician services from 2019 to 2023. At the same time, physicians continue to be reimbursed at a rate that has failed to keep pace with rising costs of providing care. Solutions that focus on

curtailing Medicare spending by limiting per service payment amounts will fail to address the key issues that are driving an increasing cost curve.

As discussions around evaluating Part B spending continue, we want to emphasize that evaluating Part B spending in isolation without including other Medicare cuts presents an incomplete, narrow, and fragmented picture of Medicare expenditures. Investments in outpatient and preventative services can offset costly emergency department use, hospitalizations, and intensive post-acute care. However, current payment policy does not fully account for this dynamic. Any policies MedPAC considers intended to constrain Part B spending should account for their potential effects on total spending across all interrelated parts of Medicare, while ensuring beneficiary access to high-quality care. Medicare payment policy must prioritize stable and predictable reimbursement that incentivizes early, proactive, and prevention-oriented beneficiary engagement while reflecting rising costs. Not only would this help ensure patients get the right care in the right setting, but it is also necessary for medical groups and health systems to maintain staffing, invest in technology and care coordination, and continue to transition toward high-value care.

Therefore, AMGA urges MedPAC to advocate for the statutory transition to a structured and predictable Medicare Part B payment system that includes a baseline inflationary adjustment based on the Medicare Economic Index (MEI) as part of the annual PFS update, as similarly recommended in MedPAC's March 2025 Report to Congress. Such an approach would better reflect the actual costs of providing care, while supporting beneficiary access and the long-term sustainability of the Medicare program. Looking ahead, the gap between clinician reimbursement and the cost of care is projected to widen. As MedPAC has previously noted, the Centers for Medicare and Medicaid Services (CMS) estimates that the MEI will rise by an average of 2.3% annually from 2025 through 2033. Yet under current policy, clinician reimbursement remained flat in 2025 and will increase beginning in 2026 by only 0.75% annually for Advanced Alternative Payment Model (APM) participants and 0.25% for all other clinicians. AMGA agrees with MedPAC that linking payment updates to the MEI would help Part B providers sustain their practices and continue delivering high-value care.

AMGA also urges MedPAC to consider the widening gap between Medicare and commercial reimbursement when evaluating both Part B spending and provider consolidation. Notably, MedPAC found that preferred provider organization (PPO) reimbursement for clinician services increased from 140% of Medicare FFS rates in 2023 to 147% in 2024. This growing variation is important context for understanding the financial pressures providers face, and instead of advancing value, they may be forced to freeze hiring, reduce staff, cut population health initiatives, scale back investments in certain programs, or limit services for Medicare beneficiaries.

Reducing Administrative Burden

AMGA appreciates Commissioner Brian Miller's comments on overregulation and its harmful consequences to productivity and practice sustainability. Many of the laws and regulations governing Medicare are outdated and hinder the operations of group practices and health systems without improving access to care or the quality of care. Their cost is significant: Physician practices spend more than $15.4 billion and 785 hours per physician each year reporting quality measures. In addition, Medicare Advantage prior authorization denials are overturned at an 80% success rate, diverting resources and time from patient care.

Reducing this burden is essential to improving productivity and sustaining the transition to high-value care. AMGA has several recommendations derived from the AMGA MACRA and Value-Based Care Task Force:

- Streamline quality measurement around an outcomes-focused measure set and reduce unnecessary reporting burdens.

- High-value models of care should be exempt from self-referral laws, and providers should have the flexibility to identify the most appropriate post-acute care facilities for their patients.
- The requirement for a three-day inpatient hospital stay as a prerequisite for coverage of skilled nursing facility (SNF) care is outdated and unnecessarily restrictive. Eliminating it would reduce hospital congestion, improve care coordination, and lower healthcare costs.
- Simplify Annual Wellness Visit documentation, as extensive documentation and data collection and entry are required, much of which is redundant, since it has already been recorded in the patient's record.
- Reform Medicare Advantage prior authorization to eliminate delays in care. Prior authorization results in significant delays and administrative burdens and should be eliminated to the extent possible.

The burdens described above fall hardest on small and rural practices, which lack the resources to absorb compliance costs. It is imperative that Medicare's rules support, rather than impede, the delivery of efficient, high-value care. A detailed list of regulatory barriers and their citations is attached for the Commission's reference.

AMGA would like to thank MedPAC for its ongoing work in support of the transition to value-based care and the continued efforts to develop payment update recommendations that keep up with inflation.

We thank you for your consideration of our comments, and AMGA would welcome the opportunity to meet with MedPAC staff to discuss our concerns and possible solutions to these issues.

Should you have any questions, please contact AMGA's Senior Director of Regulatory Affairs Darryl M. Drevna at 703.838.0033 ext. 339 or ddrevna@amga.org.

Sincerely,



Jerry Penso, MD, MBA
President and Chief Executive Officer, AMGA