Alliance of Specialty Medicine

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MEDICARE PHYSICIAN PAYMENT REFORM

Stabilize Payment and Ensure Successful Value-Based Care Incentives

H.R. 879/S. 1640, *Medicare Patient Access and Practice Stabilization Act*

REQUEST

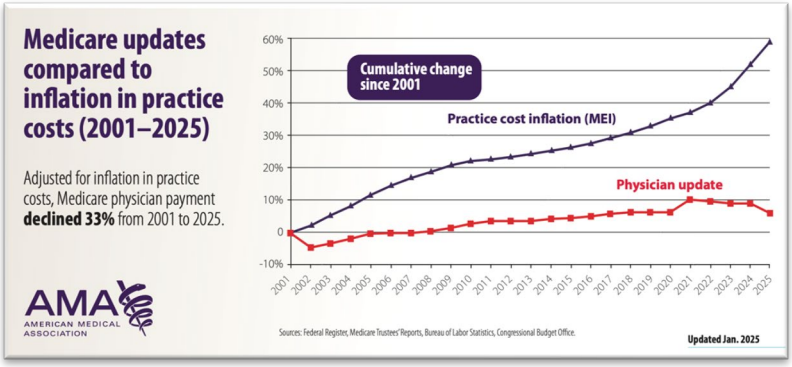
The Alliance of Specialty Medicine (Alliance) recognizes that Congress provided a 2.5% increase to the Medicare conversion factor in 2026 but calls on Congress to embrace long term reforms to **prevent recurring annual Medicare cuts** and **enact permanent solutions to stabilize Medicare physician payments and improve Medicare physician quality programs.** The Alliance also urges members of Congress to address the 2.83% cut for 2025 that went into effect on January 1st, and **cosponsor the bipartisan *Medicare Patient Access and Practice Stabilization Act* (H.R. 879/S. 1640)**.

BILL SUMMARY

The *Medicare Patient Access and Practice Stabilization Act* would increase the Medicare physician payment conversion factor for the remainder of 2025 to address the 2.83% cut that went into effect on January 1 and account for inflation.

BACKGROUND

Medicare Physician Fee Schedule Flaws



As shown in the chart (right), physician practice costs were on the rise prior to the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).* The price of medical supplies, equipment, and clinical and administrative labor was at substantial levels, as demonstrated by MEI.[1] MACRA established physician payment updates without a yearly automatic inflation adjustment unlike other Medicare providers, which receive annual payment updates based on an inflation proxy, such as the Consumer Price Index (CPI). Given the lack of an automatic payment update, when adjusted for inflation in practice costs, Medicare physician payments declined 33% from 2001 to 2025.[2] While Congress anticipated that physicians would receive value-based incentives and differential payment updates based on their participation in either the Merit-based Incentive Payment System (MIPS) or the Alternative Payment Model (APM) tracks, many factors have led to insufficient payment updates, particularly when compared to the effort and resources physicians must devote to participate.

The Medicare Trustees[3] and other policy experts have raised concerns about the lack of an inflation measure in the Medicare Physician Fee Schedule (MPFS). According to the Medicare Payment Advisory Commission (MedPAC), this downward financial pressure on physicians has forced many to sell their practices to health systems and private equity groups and enter into employment arrangements with these entities, further consolidating health care systems and increasing health care costs to taxpayers and beneficiaries.[4] Research by the American Medical Association (AMA) found that 42.2% of physicians remained in private practice as of 2024, but many are selling their practices because

[1] https://fixmedicarenow.org/sites/default/files/2025-06/25-1349100 Medicare-inflation-phy-cost %281%29.pdf
[2] https://fixmedicarenow.org/sites/default/files/2025-01/Medicare Gap Chart_2025.pdf
[3] https://www.cms.gov/oact/tr/2025
[4] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf

inadequate payment rates, soaring resource costs, and overwhelming regulatory and administrative burdens make independence increasingly unsustainable.[5]

Beyond the challenges in physician payment created under MACRA, the MPFS is plagued by other challenges, including requirements to maintain budget neutrality and irregularly timed updates to practice expense data used to set payments. In fact, physicians continue to "pay down" the significant budget neutrality adjustment prompted by the Centers for Medicare & Medicaid Services (CMS) 2021 and 2023 implementation of increased relative values for office and outpatient evaluation and management (E/M) services and inpatient and other E/M services, respectively, as well as absorb CMS' 2022 implementation of revised clinical labor prices (an update that lagged two decades). For 2024, CMS commenced paying for a new E/M add-on payment that Congress previously prohibited CMS from implementing, prompting yet another substantial budget neutrality adjustment and concomitant reduction to the MPFS conversion factor (CF). We appreciate congressional efforts to reduce CF cuts temporarily; however, Congress has still allowed year after year of cuts to the MPFS CF, and this pattern is unsustainable. The 2025 MPFS CF equals $32.35. In 2016, it was almost $36.00.

Barriers to Participating in Value-based Care Programs

Many specialty physicians also face major barriers under MACRA's Quality Payment Program (QPP), including MIPS and Advanced APMs. Both tracks of the QPP have been implemented in a manner that limits meaningful participation among many specialists. For example, MIPS remains overly complex, and program rules change from year to year. It also relies on siloed assessments of quality and cost rather than a more comprehensive approach to value and disincentivizes investments in the development and use of more meaningful specialty-specific quality measures and clinical data registries. At the same time, APMs remain largely focused on primary care. Even when specialists participate in more focused, episode-based models, high APM participation thresholds under the QPP make this track inaccessible to many specialists. As a result, many specialists have struggled to shift to value-based payment models and to qualify for the QPP's 5% APM incentive payment, which expired after the 2024 payment year. Therefore, the Alliance urges Congress to work with CMS to ensure that the QPP offers specialists more clinically relevant participation pathways; and restore and extend the full 5% APM incentive payment and maintain or lower the QPP's APM thresholds to incentivize specialty physician movement into APMs, including more relevant models that have not yet materialized.

CONTACT

To cosponsor **H.R. 879**, please contact Mclean.Piner@mail.house.gov (Rep. Murphy) or Seamus.McKeon@mail.house.gov (Rep. Panetta).

To cosponsor S. 1640, please contact **S. 1640** Max_Seltzer@marshall.senate.gov (Sen. Marshall).

RESOURCES

- Alliance response[6] to the Senate Committee on Finance white paper "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B" (June 14, 2024)
- Alliance statement[7] submitted for Senate Committee on Finance hearing "Bolstering Chronic Care through Medicare Physician Payment" (April 11, 2024)
- Alliance response[8] to the Centers for Medicare and Medicaid "Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information" (June 12, 2025)

[5] https://www.ama-assn.org/practice-management/private-practices/smaller-share-doctors-private-practice-ever
[6] https://specialtydocs.org/wp-content/uploads/2024/06/Alliance-of-Specialty-Medicine-response-to-SFC-physician-reimbursement-white-paper-06.14.2024.pdf
[7] https://specialtydocs.org/wp-content/uploads/2024/05/Alliance-of-Specialty-Medicine-Statement-for-the-Record-SFC-Bolstering-Chronic-Care-Thru-Medicare-Physician-Payment-04.11.2024.pdf
[8] https://specialtydocs.org/alliance-response-to-cms-medicare-deregulation-rfi/

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PRIOR AUTHORIZATION REFORM
S. 1816/H.R. 3514, *Improving Seniors' Timely Access to Care Act*
H.R. 2433, *Reducing Medically Unnecessary Delays in Care Act*

REQUEST

The Alliance of Specialty Medicine (Alliance) urges members of Congress to **cosponsor and advance the *Improving Seniors' Timely Access to Care Act* (S. 1816/H.R. 3514)** introduced in the Senate by Sens. Roger Marshall, MD (R-KS) and Mark Warner (D-VA), and in the House of Representatives by Reps. Mike Kelly (R-PA), Suzan DelBene (D-WA), John Joyce, MD (R-PA), and Ami Bera, MD (D-CA). The Alliance also asks members to **cosponsor and advance the *Reducing Medically Unnecessary Delays in Care Act* (H.R. 2433)** introduced by Reps. Mark Green, MD (R-TN), Greg Murphy, MD (R-NC), and Kim Schrier, MD (D-WA).

BILL SUMMARIES

The ***Improving Seniors' Timely Access to Care Act*** would:

- Establish an electronic prior authorization (PA) process for Medicare Advantage (MA) plans including standardization for transactions and clinical attachments;
- Increase transparency around MA prior authorization requirements and its use;
- Clarify the Centers for Medicare and Medicaid Services' (CMS) authority to establish timeframes for e-PA requests including expedited determinations, real-time decisions for routinely approved items and services, and other PA requests;
- Expand beneficiary protections to improve enrollee experiences and outcomes; and
- Require the U.S. Department of Health and Human Services (HHS) and other agencies to report to Congress on program integrity efforts and other ways to further improve the e-PA process.

The ***Reducing Medically Unnecessary Delays in Care Act*** would ensure that prior authorization decisions in Medicare and MA are made by board-certified physicians in the same specialty as the physician of the treatment or disease in question, and direct plans to comply with requirements around medical necessity and written clinical criteria.

BACKGROUND

Prior authorization is a cumbersome process that requires physicians to obtain pre-approval for medical treatments or tests before rendering care to their patients. The process for obtaining this approval is lengthy and typically requires physicians or their staff to spend the equivalent of two or more days each week negotiating with insurance companies — time that would better be spent taking care of patients. Patients are now experiencing significant barriers to medically necessary care due to prior authorization requirements for items and services that are eventually routinely approved.

Specialty physicians and their patients are often subject to prior authorizations and other utilization management tactics in the MA program. Generally, utilization management processes delay enrollee access to medically necessary care and treatments and create considerable, unnecessary administrative burdens for specialty physicians. Equally concerning, these tactics are a leading cause of physician burnout, forcing many to retire early or leave the practice of medicine. While utilization management processes, such as prior authorization, may be

appropriate in some situations, the HHS Office of Inspector General has found that MA plans use prior authorizations to deny medically necessary care that meets coverage requirements under traditional Medicare and is supported by the enrollee's medical records.[1]

The *Improving Seniors' Timely Access to Care Act* codifies MA prior authorization regulatory changes that went into effect on January 1, 2024, and reflects similar legislation that passed the House of Representatives unanimously by voice vote during the 117th Congress. More than 230 national and state organizations support the legislation.[2]

ALLIANCE SURVEY & KEY FINDINGS

In the fall of 2022, the Alliance conducted a survey of over 800 specialty physicians on the topic of utilization management. The findings underscore the burden of utilization management protocols on the practice of medicine — both in terms of the negative impact on patient care and the increased administrative onus on medical practices.[3] Respondents overwhelmingly indicated that the use of prior authorization has increased across all categories of services and treatments:

- Over 93% of respondents answered that prior authorization has increased for procedures;
- More than 83% answered that prior authorization has increased for diagnostic tools, such as labs and even basic imaging; and
- Two-thirds (66%) responded that prior authorization has increased for prescription drugs, with physicians noting that even many generic medications now require pre-approvals.

Given these significant problems, the Alliance supports opportunities to meaningfully improve utilization management practices, such as prior authorization, to reduce administrative burdens and ensure safe, timely and affordable access to care for patients.

CONTACTS

To cosponsor **S. 1816**, please contact Max_Seltzer@marshall.senate.gov (Sen. Marshall) or Colleen_Nguyen@warner.senate.gov (Sen. Warner).

To cosponsor **H.R. 3514**, please contact Alex.Sells@mail.house.gov (Rep. Kelly) or Mariah.Baker@mail.house.gov (Rep. DelBene).

To cosponsor **H.R. 2433**, please contact Henry.VanderToll@mail.house.gov (Rep. Green) or Amy.Zhou@mail.house.gov (Rep. Schrier).

[1] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp.
[2] https://docs.google.com/document/d/19OqthcWUvWTjWqefB6WaRHIK-KlqDpad_NjRc5kwnl0/edit?usp=sharing
[3] https://specialtydocs.org/wp-content/uploads/2022/12/ASM-2022-Survey-Summary-Findings-.pdf

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MEDICARE ADVANTAGE
S. 1105, *No UPCODE Act*

REQUEST

The Alliance of Specialty Medicine (Alliance) urges senators to **cosponsor and advance the bipartisan *No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act* (S. 1105)** introduced by Sens. Bill Cassidy, MD (R-LA) and Jeff Merkley (D-OR) which would address the widespread and well-documented distortions in the Medicare Advantage risk adjustment system. The Alliance hopes to see companion legislation introduced in the House of Representatives.

BILL SUMMARY

To address perverse financial incentives that are driving Medicare Advantage health plans to overstate the severity of enrollees' health conditions, the *No UPCODE Act* would:

- Develop a risk-adjustment model that uses two years of diagnostic data instead of just one year;
- Limit the ability to use old or unrelated medical conditions to inflate the cost of care;
- Ensure that Medicare is only charged for treatment related to relevant medical conditions; and
- Close the gap between how a patient is assessed under traditional Medicare and Medicare Advantage.

BACKGROUND

Although MA was designed to cut costs through private-sector efficiency, it now costs significantly more than traditional Medicare. According to the March 2025 *Report to the Congress* from the Medicare Payment Advisory Commission (MedPAC), Medicare will spend about 20% more per MA enrollee in 2025—an estimated $84 billion in excess—largely due to coding intensity.[1] MA plans profit by reporting additional diagnoses, inflating patients' risk scores and increasing government payments, even if those diagnoses are not actively treated. The Congressional Budget Office estimates that using two years of diagnostic data (instead of one year) to calculate risk scores, and excluding diagnoses from health risk assessments, would save Medicare $124 billion over ten years.[2]

This systemic overpayment has created administrative burdens and payment pressures for specialty physicians, especially in fields like rheumatology and ophthalmology, especially among retina specialists. Plans have dramatically increased the volume of chart reviews targeting network physicians—not to evaluate quality of care, but to extract additional diagnoses to inflate risk scores. Alliance members report that some specialty practices have been asked to produce as many as 1,800 charts for a single coding audit—often presented as CMS-mandated Risk Adjustment and Data Validation (RADV) audits—diverting limited administrative resources and distracting clinical staff from patient care. Additionally, some MA plans use incentives to influence physicians—offering bonuses for more documented diagnoses and penalizing those who don't comply. Certain contracts even allow plans to mine data directly from electronic health records, raising concerns about privacy and misuse.

CONTACT

To cosponsor S. 1105, please contact Parker_Reynolds@cassidy.senate.gov (Sen. Cassidy) or Becca_Damante@merkley.senate.gov (Sen. Merkley).

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[1] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

[2] http://www.cbo.gov/publication/60557, p.22

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GRADUATE MEDICAL EDUCATION
H.R. 3890, *Resident Physician Shortage Reduction Act*

REQUEST

The Alliance of Specialty Medicine (Alliance) urges members of Congress to **cosponsor and advance the bipartisan *Resident Physician Shortage Reduction Act* (H.R. 3890)** introduced by Reps. Terri Sewell (D-AL) and Brian Fitzpatrick (R-PA). The Senate companion bill will soon be introduced, and the Alliance urges senators to join Sens. John Boozman (R-AR) and Raphael Warnock (D-GA) as original cosponsors.

BILL SUMMARY

To address the physician workforce shortages in many specialties that will jeopardize access to care, the *Resident Physician Shortage Reduction Act* will improve the nation's graduate medical education (GME) system and help to preserve access to specialty care by:

- Increasing Medicare-supported GME residency slots by 14,000 over the next seven years;
- Specifying priorities for distributing the new slots (e.g., states with new medical schools); and
- Studying strategies to increase the diversity of the health professional workforce.

BACKGROUND

According to the Association of American Medical Colleges, the United States faces an overall shortage of up to 124,000 physicians by 2034, including 77,100 specialty and 48,000 primary care physicians.[1] Shortages will be particularly acute in the coming years for neurosurgeons, urologists, rheumatologists, ophthalmologists, cardiologists, gastroenterologists, plastic and reconstructive surgeons, dermatologic surgeons, orthopaedic surgeons, and general surgeons. It is especially critical to act now because specialty physicians require up to seven years (even longer if they pursue a post-residency fellowship) of post-graduate residency training compared to three years for primary care physicians. Given the increased demand created for their services by an aging population and the concern that more physicians are leaving medical practice early due to burnout, Congress needs to take steps now to ensure a fully trained specialty physician workforce for the future.

Congress has taken important steps to address the physician shortage crisis by approving 1,200 new Medicare-supported GME slots in the *Consolidated Appropriations Act, 2021* (P.L. 116-260) and the *Consolidated Appropriations Act, 2023* (P.L. 117-73). However, this falls far short of what is needed to ensure an adequate supply of physicians and allow the graduate medical education system to operate optimally.

CONTACT

To cosponsor **H.R. 3890**, please contact Cameryn.Blackmore@mail.house.gov (Rep. Sewell) or Clare.Dentner@mail.house.gov (Rep. Fitzpatrick).

To be an original cosponsor of the **Senate bill**, please contact Kathleen_Bochow@boozman.senate.gov (Sen. Boozman) or Gabriella_Vesey@warnock.senate.gov (Sen. Warnock).

[1] https://www.aamc.org/data-reports/workforce/report/physician-workforce-projections

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REPRESENTING MORE THAN 100,000 SPECIALTY PHYSICIANS

American Academy of Facial Plastic & Reconstructive Surgery

American Academy of Otolaryngology–Head and Neck Surgery

American Association of Neurological Surgeons

American College of Mohs Surgery

American Gastroenterological Association

American Society for Dermatologic Surgery Association (ASDSA)

American Society of Cataract and Refractive Surgery

American Society of Echocardiography

American Society of Plastic Surgeons

American Society of Retina Specialists

American Urological Association

Coalition of State Rheumatology Organizations

Congress of Neurological Surgeons

National Association of Spine Specialists

The Society of Interventional Radiology (SIR)

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