



June 4, 2026

The Honorable Brett Guthrie  
Chair  
House Committee on Energy & Commerce  
2125 Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Frank Pallone  
Ranking Member  
House Committee on Energy & Commerce  
2323 Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Morgan Griffith  
Chair, Health Subcommittee  
House Committee on Energy & Commerce  
2125 Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Diana DeGette  
Ranking Member, Health Subcommittee  
House Committee on Energy & Commerce  
2323 Rayburn House Office Building  
Washington, D.C. 20515

**Re: Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms**

Dear Chairs Guthrie and Griffith and Ranking Members Pallone and DeGette:

The American Podiatric Medical Association (APMA) thanks the subcommittee for holding this hearing to improve care for seniors, examine efforts under the Medicare Access and CHIP Reauthorization Act (MACRA) to reform Medicare physician payment, and explore current challenges in Medicare physician fee schedule.

APMA represents the vast majority of the more than 15,000 licensed podiatric physicians and surgeons, also known as doctors of podiatric medicine (DPMs), in the United States. Our members diagnose and treat conditions of the foot and ankle that affect millions of Americans, including individuals with diabetes, circulatory disorders, and other chronic diseases. Podiatric physicians play a critical role in preventing lower extremity complications, reducing hospitalizations and amputations, improving mobility, and preserving quality of life for Medicare beneficiaries.

APMA appreciates Congress' continued efforts to identify a practical and sustainable approach to physician payment reform and ensure that Medicare beneficiaries maintain access to high-quality specialty care. Below are recommendations to strengthen the Medicare physician payment system, modernize value-based care programs, and improve the long-term sustainability of physician practices.

**Medicare Physician Payment Reform**

The Medicare Physician Fee Schedule (MPFS) no longer reflects the cost of providing care and keeping a practice open, which impacts patient access. While practice costs continue to rise due

to inflation, staffing shortages, medical supplies, technology investments, compliance requirements, and professional liability expenses, physicians remain the only Medicare providers without a permanent inflationary payment update.

When adjusted for inflation, Medicare physician reimbursement has declined 33 percent since 2001. This continued financial pressure threatens physician practice sustainability and patient access to care, particularly in rural, underserved, and independent practice settings. Sustainable reimbursement is essential to ensure continued access to foot and ankle care, especially for patients with diabetes and other chronic conditions who rely on podiatric physicians to prevent more costly and invasive interventions.

In Medicare Payment Advisory Committee's (MedPAC) June 2025 Report to Congress, they recommended an overhaul to how Medicare updates physician payments, calling for a long-term inflation-adjusted approach that reflects the cost of providing care. MedPAC recommended replacing the updates with a permanent, inflation-based formula tied to the Medicare Economic Index (MEI), such as MEI minus one percentage point. Although MedPAC's recommendation is not the full MEI that Medicare physicians need to ensure sustainability in the face of ever-rising costs of delivering care, it is a meaningful step in the right direction to provide permanent updates that reflect practice cost inflation.

Without a permanent inflationary update, physician practices will continue to face a crisis. Sustainable reimbursement is essential to ensure continued access to foot and ankle care, especially for patients with diabetes and other chronic conditions who rely on podiatric physicians to prevent more costly and invasive interventions.

Additionally, under current law, any change CMS makes to the MPFS, whether adding a new code, revaluing an existing service, or adjusting payment for a procedure, must be "budget neutral" which means that it cannot increase total Medicare physician spending.

### **Proposed Legislative Reforms:**

APMA urges Congress to provide permanent, inflation-based update equal to MEI, without reductions or caps. However, APMA also recognizes proposals of MEI minus 1 percentage point (or higher) as meaningful step in the right direction to provide permanent updates that reflect practice cost inflation.

- Congress must modernize and update the budget neutrality mechanism by increasing the threshold from \$20 million to \$54.3 million, indexing it to MEI every five years, providing updates to direct costs used to calculate practice expense relative value units (RVUs) not less often than every five years, and limiting year-to-year variance in the conversion factor by 2.5 percent.

### **Merit-Based Incentive Payment System (MIPS)**

APMA supports efforts to reform MIPS and transition toward a more clinically meaningful, less burdensome value-based care framework. As currently structured, MIPS remains overly

complex, administratively burdensome, and frequently disconnected from meaningful patient outcomes.

On average, MIPS compliance annually costs over \$12,800 per physician and requires more than 200 hours per physician, according to a study published in *JAMA Health Forum*. Practices absorb this enormous administrative and cost burden with no evidence of improvements in patient outcomes, quality of care, or reduction in costs. Solo and small practices are disproportionately impacted, frequently in rural and underserved communities. Furthermore, the current traditional MIPS model lacks meaningful, clinically relevant measures that directly link cost to quality and patient outcomes. Instead, physicians are scored via four separate siloed categories that primarily reflect a clinician's ability to navigate an administratively burdensome reporting program.

### **Proposed Legislative Reforms:**

- Congress must reform the MIPS and should consider legislative proposals like a data-driven performance payment system to strengthen value-based care by increasing transparency, meaningfully engaging underrepresented specialties, and overhauling MIPS to reduce burden and better support patient care. By reducing the maximum MIPS reporting penalty and implementing requirements that reinvest penalties into assistance for under-resourced practices, the proposal would help rural or small practice transition towards value-based care and lessen financial burdens that inadvertently hinder patient access.
- *Maintain Solo and Small Practice Flexibility:* APMA urges Congress to ensure that meaningful flexibilities for solo and small practices are fully integrated into any new program replacing MIPS. These practices are disproportionately burdened under the current system due to limited staffing and financial resources. Any program successor must recognize this uneven playing field by offering scaled requirements, streamlined measure options, bonus scoring opportunities, and multiple pathways for participation through flexible submission mechanisms.
- *Quality Reform Task Force:* APMA supports the creation of a Quality Reform Task Force (QRTF) and strongly endorses its explicit focus on prioritizing specialties that currently lack meaningful quality measures. However, to ensure appropriate stakeholder representation, Congress must specify that the term “physician” include all physician types identified in §1861(r) of the Social Security Act.
- *Reliance on Actionable Value-Based Measures:* The QRTF must develop meaningful, clinically relevant measures that directly link cost to quality and patient outcomes rather than measures that merely promote guideline conformity or generalized cost reduction. Claims-based measures have well-documented limitations, as demonstrated by challenges in MIPS cost measure development and attribution. Measures should instead generate actionable, patient-centered insights that physicians can apply to real-time clinical decision-making, not incentivize indiscriminate reductions in utilization. Without this focus, cost and resource use categories risk being perceived as encouraging “less care” rather than better care, undermining clinician trust and patient outcomes. By centering its

work on actionable, value-based measures, the QRTF can help ensure that cost accountability aligns with improved quality, better patient experiences, and more sustainable care delivery.

- *Broaden Quality Measurement Beyond EHR and Registry Measures:* APMA urges Congress not to limit measures to only those using certified electronic health records and/or registries. While we appreciate the goal of facilitating data aggregation and provider burden reduction, clinicians use widely varying EHR systems, and interoperability failures remain a major concern. Poorly implemented automation risks increasing provider burden.
  - APMA recommends that Congress direct agencies such as the Office of the National Coordinator for Health Information Technology (ONC) to establish clear standards for accuracy, transparency, and accountability, with meaningful enforcement that targets those who restrict data exchange without further burdening clinicians who lack control. Ensuring automation should be the responsibility of EHR and technology vendors, not clinicians. Congress should not overly restrict measure development and use before the necessary interoperability is in place.
  - APMA also strongly opposes a heavy reliance on registry use. In addition to the underlying interoperability concerns, registries are costly for clinicians, with fees varying based on practice size and the number of MIPS categories reported, and EHR vendors may charge additional fees simply to enable data sharing.
- *Definition of Insufficiency as It Relates to Specialty Measure Evaluation:* Congress needs to acknowledge the current gap of meaningful measures, measure sets, and MIPS Value Pathway measures (MVPs) for a number of specialties and prioritize such specialties with CMS and the QRTF. To ensure that Congress’s good faith intent is interpreted correctly, APMA recommends that Congress further define or clarify “insufficient.” Where a measure set relies predominantly on broad, non-specific measures that do not meaningfully reflect the unique services, patient populations, or clinical decision-making of the specialty, this is still functionally insufficient. Similarly, the use of a MIPS Value Pathway (MVP) that incorporates the same generalized measures does not resolve this deficiency. Specialties whose measure sets fall into this “insufficient” definition should be engaged, despite having a specialty set or an MVP.
- *Appropriate Use Criteria (AUC) Program:* APMA urges that the AUC program under MIPS should not be revived. This program was delayed indefinitely by CMS in 2024 after years of postponements; it would only impose a substantial administrative burden on clinicians ordering advanced imaging for Medicare Part B outpatients with little evidence that it supports patient care improvements.

### **Alternative Payment Models (APMs) and Center for Medicare and Medicaid Innovation (CMMI)**

Podiatric physicians and other specialists continue to face limited opportunities to meaningfully participate in Advanced APMs. Existing models frequently fail to account for specialty-specific clinical care, meaningful quality measures, or realistic pathways for participation.

### **Proposed Legislative Reforms:**

- APMA supports requirements to increase transparency when CMMI models are expanded, terminated, or substantively modified. Greater clarity and advance notice are essential to ensure stakeholders can meaningfully evaluate models, plan participation, and contribute to successful implementation.
- APMA also supports mandated public reporting on actual savings achieved by CMMI models. Consistent, standardized reporting on realized savings and quality outcomes is critical to assessing model performance, ensuring accountability, and building confidence among providers considering participation in APMs.
- Further, APMA also supports the requirement for a Government Accountability Office (GAO) report on barriers to participation in value-based care models. APMA recommends that, in addition to MedPAC, Congress also specify that the Comptroller General of the United States also engage impacted stakeholders directly through a formal request for information. Ensuring that the clinician perspective is directly reflected will help policymakers address obstacles facing clinicians and strengthen the design of future APMs to promote broader adoption and long-term success.

### **Conclusion**

The reforms outlined above would help stabilize Medicare physician payment, reduce unnecessary administrative burden, improve physician participation in value-based care, and preserve Medicare beneficiary access to specialty care. APMA stands ready to work with the Subcommittee, with both Republican and Democratic leadership, to advance meaningful physician payment reforms that support sustainable practices and improve patient outcomes.

APMA thanks the Subcommittee for considering these reforms and its continued attention to the affordability and access challenges facing American patients and the podiatric physicians who care for them.

If we can be of any assistance, please contact Ben Melano, Director of Government Affairs, at [bmelano@apma.org](mailto:bmelano@apma.org).

Sincerely,



Patrick DeHeer, DPM  
President