American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

May 20, 2026

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

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

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for holding today's critically important hearing entitled, "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms." We appreciate the committee's consideration of the current Medicare physician payment landscape and what policy changes are needed to truly modernize and stabilize the Medicare program for physicians and, most importantly, the patients we serve.

As you well know, the Medicare Access and CHIP Reauthorization Act (MACRA; P.L. 114-10) was intended to permanently resolve Medicare's flawed Sustainable Growth Rate (SGR) payment formula and help transition our health care system to one that rewards value, rather than volume. As we looked to move away from traditional fee-for-service (FFS) as the standard, MACRA was designed to establish value-based payment pathways – the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) – as well as streamline the numerous quality reporting programs under Medicare.

However, in practice the implementation of MACRA has not proven to be the fix that was promised. While the law helped address the short-term physician payment issues caused by the SGR, for the last several years the Medicare Trustees Report has reiterated that there remain "…important long-range concerns that will almost certainly need to be addressed by future legislation."[1] These concerns include specified payment updates not accounting for varying economic factors, including not keeping up with the pace of inflation and failing to rectify increasing gaps between the payment updates and growing physician costs. Given these concerns, the Trustees expect "…access to Medicare-participating physicians to become a significant issue in the long term."

We believe that with improvements developed in collaboration with Congress, regulators, and stakeholders, MACRA (or a subsequent framework) can be significantly

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[1] https://www.cms.gov/files/document/2025-medicare-trustees-report.pdf

more effective in facilitating a successful transition to value-based care delivery. It does not necessitate the wholesale dismantling of the current system as we did with the SGR, but does require more regular oversight and better integration of the varying specialties as meaningful participants in the process. This will help us develop a more viable and stable payment system that truly incentivizes high-quality, cost-effective care. To this end, ACEP responded to a recent bipartisan request for information from the House GOP Doctors Caucus and Congressional Doctors Caucus, detailing some of our proposals on legislative reforms needed to improve, modernize, and stabilize the Medicare physician payment system, and we appreciate their ongoing efforts to drive needed change.

Financial stability and certainty are critical in ensuring that Medicare can fulfill its promise to the millions of American seniors that deserve and depend upon this program. The annual issue of significant Medicare physician payment cuts not only threatens the viability of the health care safety net but also affects our ability to effectively partner with Congress to address other critical challenges facing the physician community, and most importantly, our ability to advocate on behalf of our patients. We share legislators' significant frustrations with the perennial task of finding costly, short-term fixes for long-term problems, and we support efforts to provide greater stability and certainty in the Medicare system and thank you once again for the Committee's attention to this critical issue.

Growing Financial Pressures and Unique Concerns for Emergency Medicine

Emergency physicians serve on the front line of the health care system and provide care under circumstances and laws that are unique among other physician and provider specialties. Both by oath and under the federal Emergency Medical Treatment and Labor Act (EMTALA), emergency physicians provide lifesaving emergency care to every patient regardless of their insurance status or ability to pay. As a result, we provide more uncompensated care than any other physicians or providers, and combined with growing financial and operational pressures, the health care safety net we provide is under increasing strain.

The burden of uncompensated care only continues to grow, particularly in communities with high populations of uninsured patients. A report issued by RAND in April 2025, "Strategies for Sustaining Emergency Care in the United States,"[2] brings this uncompensated care burden into sharp relief – across all payers, **20 percent of emergency physician payments go unpaid, representing $5.9 billion in annual losses**. Additionally, in order to ensure 24/7/365 access to the emergency department (ED), we work under more specialized staff and standby requirements than other types of medical providers so that we can meet the needs of patients who experience a wide range of emergencies every day, such as heart attacks, strokes, trauma, mental health conditions, and countless others.

Declining payments for emergency services further compound the financial pressure on emergency medicine. From 2018-2022, commercial insurance payments to emergency physicians dropped 10.9 percent in-network and 47.7 percent out-of-network. Medicare and Medicaid payments per visit also dropped 3.8 percent during the same period. Together, Medicare and Medicaid account for more than 65 percent of ED visits (33.6 percent and 32 percent, respectively), so the cumulative impact of continued reimbursement cuts in federal programs alone has a disproportionate effect on emergency medicine. Additionally, harmful payer reimbursement practices such as those detailed in ACEP's statement for the record for recent congressional hearings with insurance company executives, as well as growing health care consolidation, not only add financial burdens but are also major sources of stress and burnout for emergency physicians.

Necessary Structural Improvements for the Medicare Physician Payment System

ACEP strongly supports efforts to stabilize the Medicare physician payment system, including:

[2] https://www.rand.org/pubs/research_reports/RRA2937-1.html

- Establishing a permanent inflationary update based upon the Medicare Economic Index (MEI), such as the bipartisan "Strengthening Medicare for Patients and Providers Act" (H.R. 6160) led by Representatives Raul Ruiz, MD (D-CA) and Gus Bilirakis (R-FL).
- Implementing improvements and updates to the Physician Fee Schedule's (PFS) budget neutrality rules to mitigate year-to-year fluctuations in the conversion factor, such as those proposed in the "Provider Reimbursement Stability Act" (H.R. 8163) led by Representatives Greg Murphy, MD, and Jimmy Panetta (D-CA).
- Modernizing and improving the Medicare and CHIP Reauthorization Act of 2015 (MACRA) to assist in the transition toward more value-based payment models and reduce clinician burdens.

We also ask Congress to act before the end of the year to prevent any potential cut that may result from possible negative budget neutrality adjustments in the upcoming calendar year (CY) 2027 PFS rule and the expiration of temporary relief provided by Congress through the end of 2026.

<u>Modernizing MACRA: Improving the Merit-based Incentive Payment System (MIPS)</u>

Broadly, MACRA as implemented is a "one-size-fits-all" approach for physicians and other clinicians, regardless of specialty or practice model, thereby ignoring core differences between different modalities of care. A truly transformative, value-based payment system must recognize and be able to encompass different models of care:

- Non-episodic/scheduled care (primary care including chronic/longitudinal care management)
- Episodic/scheduled care (typically elective procedures, mostly specialty care)
- Episodic/unscheduled care (emergency care, urgent care

CMS tried to address this one-sized-fits-all constraint through the creation of the MIPS Value Pathways (MVPs). Under this optional approach, clinicians can report on a uniform set of measures on a particular episode or condition in order to get MIPS credit. ACEP developed an emergency medicine-focused MVP that CMS included in the first batch of MVPs starting in 2023. While we appreciate the implementation of our Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, we are generally concerned that based upon the reporting trends from its first performance year of 2023, there is limited uptake; likely as there are still not sufficient incentives to encourage clinicians to report through this MVP. Clinicians who report MVP data also have the option of reporting through Traditional MIPS, and CMS takes the highest score. Based on the first year of data, not only did only a small number of clinicians report through MVPs, but most who did also chose to report Traditional MIPS. These clinicians received a higher score overall in Traditional MIPS than in MVPs. For the emergency medicine MVP, 2,912 clinicians registered to report the MVP and 1,112 reported MVP data-- but only 45 clinicians received a final score from the MVP in the 2023 performance year. It is still too early to tell whether participation will increase and whether the MVP approach is a viable pathway for MIPS going forward.

There are some structural flaws within MVPs that may also be leading to low participation rates. There are no additional financial incentives for participating in an MVP – and since clinicians are generally performing better in Traditional MIPS than MVPs anyway, it may not be worthwhile for clinicians to spend additional time and effort to report to an MVP.

To help ensure MACRA's success, we ask Congress to consider refining MIPS overall, including the MVP approach established by CMS, in order to better tailor the program to the type of care a physician actually typically delivers. For example, there could be a system in which primary care continues to use traditional quality and cost measures, scheduled care could use episodes-of-care and MVP measures, and emergency care could use its own paradigm, relying on more relevant measures like the EM cost measure with a 14-day episode (as opposed to 30-day for other specialties). Such a system would better reflect the type of work a physician performs the majority of the time.

Further, the clinician community believed when MACRA was passed that the ultimate goal was for most clinicians to transition away from MIPS to participate in Advanced APMs. Besides there not being opportunities for most specialists to participate in Advanced APMs, there should also be better, and more sustainable incentives to participate in these models.

As it stands, MIPS is currently set up for larger groups to perform well and may be a more attractive and financially viable option as there is less risk, which suggests that there should be better incentives to encourage larger groups to participate in Advanced APMs. And while MIPS is burdensome, the development of quality measures requires significant effort, time, and resources, and we do not want those to simply go away. Qualified clinical data registry (QCDR) measures should still be used – they have been refined and maintained, are specialty-specific, and have been developed for the sole purpose of improving care for patients seen by such specialists.

QCDRs are third-party intermediaries that help clinicians report under MIPS, and they have proven to be an excellent way to collect data and report quality measures. ACEP developed its own QCDR, the Clinical Emergency Data Registry (CEDR), offering dozens of EM-specific measures and QPP measures spanning five domains of care. QCDR measure owners invest significant resources into measure development, data collection, and validation. Additionally, QCDR measure owners develop these measures for use beyond MIPS reporting (e.g., research, guideline development, quality improvement, etc.). Section 1848(q)(5)(B)(ii)(l) of the Social Security Act, as added by Section 101 of MACRA requires HHS to encourage the use of QCDRs to report quality measures under MIPS. In line with this statutory requirement, ACEP has urged CMS to continue refining the QCDR option under MIPS to streamline the self-nomination process and provide better incentives for organizations, including medical associations such as ours, to continue to invest in their QCDRs and develop new, meaningful measures for specialists to use for MIPS reporting and other clinical and research purposes. Conversely, CMS should refrain from finalizing proposals that would impose significant and unreasonable burdens on QCDRs, **and we strongly urge the Committee to ensure that registries like CEDR can continue to succeed and be developed further**.

Modernizing MACRA: Expanding APM Pathways & Integrating Specialty Care

To ensure APMs deliver real improvements in cost and quality while ensuring successful scaling of innovations, we urge Congress to consider a range of options to examine why specialists, including emergency physicians, have largely been precluded from participating in APMs.

As they treat each patient, emergency physicians must make a critical decision about whether the patient should be kept for observation, admitted as an inpatient to the hospital, or discharged. Essentially, they act as a gateway to the hospital for many patients. Emergency physicians are therefore in a prime position to be meaningful participants in APMs that attempt to shift our health care system to one that rewards value over volume. However, while many emergency physicians are ready to take on the downside risk and participate in Advanced APMs, there simply are not any opportunities to do so.

For context, in order to address the gap in available Advanced APMs for emergency physicians, ACEP established an internal APM Task Force to review various APM proposals, eventually resulting in the development of an emergency medicine-focused APM, the Acute Unscheduled Care Model (AUCM; affectionately pronounced "awesome"), that we have presented to regulators for incorporation into various APM initiatives. In October 2017, ACEP submitted the AUCM proposal to the PTAC. Established by MACRA, the PTAC is tasked under statute with commenting on and recommending physician-focused APM proposals to the Secretary of Health and Human Services

(HHS) for consideration, based on a set of ten criteria established by the Secretary. After months of discussions with a Preliminary Review Team (PRT) within the PTAC, ACEP officially resubmitted the model in June 2018.

In September 2018, three emergency physicians presented the model to PTAC during a public meeting. PTAC voted on the ten criteria and determined that the AUCM proposal met all ten criteria.

PTAC Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary	Full PTAC Rating
1. Scope (High Priority)	Meets and Deserves Priority Consideration
2. Quality and Cost (High Priority)	Meets
3. Payment Methodology (High Priority)	Meets
4. Value over Volume	Meets
5. Flexibility	Meets
6. Ability to be Evaluated	Meets
7. Integration and Care Coordination	Meets
8. Patient Choice	Meets
9. Patient Safety	Meets
10. Health Information Technology	Meets

The PTAC then voted to submit the model to the HHS Secretary for full implementation, agreeing that the model has great potential to improve the way emergency care is delivered and that it fills a huge gap in the current portfolio of APMs. One member of the PTAC even stated that it was the best APM that they had reviewed to that point. Based on the vote and recommendations made during this meeting, PTAC then formally issued a report to the HHS Secretary in October 2018 stating that AUCM deserves priority consideration based upon the scope criterion.

In September 2019, HHS Secretary Alex Azar responded[3] to the PTAC's recommendation by stating that he was, "interested in exploring how the concepts in the AUCM model for care management by emergency physicians after an ED encounter could be incorporated into models under development at the CMS Center for Medicare and Medicaid Innovation (CMMI)." But despite subsequent conversations with) CMMI has not made any tangible progress on the implementation of the model at this point.

ACEP has repeatedly raised our concerns with CMS that the agency is not doing enough to engage emergency physicians in value-based payment initiatives. For example, in our response to the CY 2026 PFS and QPP proposed rule, ACEP reiterated our call that CMS prioritize the creation of additional APM opportunities for emergency physicians and other specialists, or determine how to modify existing APMs to better engage specialists and allow them to actively participate.

At this point, with little action from CMS on the AUCM, we are working with other payers beyond Medicare to try to advance the model's core principles – including Medicaid and private payers. As these payers continue to move away from traditional fee-for-service (FFS) contracts toward value-based payment arrangements, the AUCM could be an ideal APM construct for them to adopt, at least in terms of core concepts. We anticipate that some features of these private payer APMs will be different from the AUCM depending on the specifics and needs of the targeted patient population.

ACEP encourages Congress to consider legislative options including giving more weight or authority to recommendations made by the Physician Payment Technical Advisory Committee (PTAC); mandating that CMMI

[3] https://downloads.cms.gov/files/ptac-hhssecresponse-sep18-dec18.pdf

implement new models that have been recommended for adoption by the Secretary of the Department of Health and Human Services (HHS); or, at minimum, ensuring greater transparency by requiring CMMI to report to Congress why models that have been approved or recommended for adoption have not been implemented (such a report should be retroactive to encompass all models that have already gone through this process). We also urge Congress to exercise its critical oversight role to examine why emergency physicians and other specialists have largely been precluded from participating in APMs.

Refining PFS Policy Changes to Limit Unintended Consequences

In the calendar year (CY) 2026 Medicare PFS, CMS finalized two policies that, while well-intended, do not account for the needs or realities of emergency medicine.

- **Efficiency Adjustment**: CMS finalized a 2.5 percent "efficiency adjustment" for work relative value units (RVUs) and physician intra-service time for all non-time-based codes, with additional reductions expected every three years indefinitely. This policy was based on the assumption that all non-time-based services become more efficient as those services become more common, professionals gain more experience, technology improves, and other operational improvements are implemented; however, the across-the-board methodology applied by CMS does not differentiate between services that can realize efficiencies and those that cannot, or services that have already recently undergone evaluation through existing processes. Further, advances in technology do not necessarily directly reduce the time it takes to conduct specific services and interpret results.

  Though the vast majority of emergency medicine services evaluation and management (E&M) codes are not subject to the efficiency adjustment, procedures frequently performed by emergency physicians are. These include things like ultrasounds, laceration repairs, fracture care, CPR, burn treatment, intubation, among many others. Intubation, for example, is already as efficient as possible – it is a difficult procedure that has life-or-death implications. CPR is also not an expensive or overly-inflated procedure meriting an efficiency adjustment.

  While we share CMS' goal of ensuring that PFS valuations accurately reflect changes in resource use over time, we believe this policy should at least be refined to incorporate service-specific analysis and should exempt codes that have recently been revalued. Further implementation of the policy should also be delayed to allow specialty societies to provide input on where efficiencies are achievable and where the nature of the service precludes such gains.

- **Indirect Practice Expense (PE) RVU Reallocation**: CMS also finalized a policy to reduce indirect PE RVUs in the facility setting to 50 percent of the amount used in the non-facility setting (exempting maternity care codes with an MMM global period). Indirect PE is a part of the Medicare PFS intended to account for overhead and other costs, such as rent, equipment, utilities, administrative staff, and other costs.

  In the rule, CMS acknowledged that physicians practicing in facility settings may still incur indirect PE costs, and further acknowledged that facilities may incur higher overhead costs because they must be equipped and able to furnish services 24 hours a day and 7 days per week under EMTALA. However, the rule was finalized largely as proposed and without any of the exceptions or refinements that ACEP and other organizations had requested.

  CMS believes that because fewer physicians who primarily work in facilities still own their practices, their indirect PE costs do not need to be the same as those physicians who work in non-facility settings. The intent of the policy to preserve private practice and prevent further integration and consolidation is well-meaning and is a goal that ACEP strongly supports. However, this policy also does not account for the unique practice considerations for most emergency physicians.

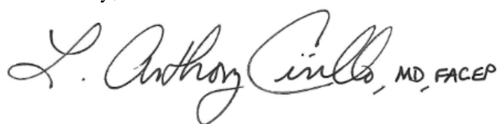
Most emergency physicians are not employed directly by hospitals, but instead provide services in hospitals as a group through contracts for their professional services. They operate independently and have their own set of operating expenses. CMS' Indirect PE reduction does not account for the variations in sizes, structures, and associated operating expenses of practices like these. It also disproportionately affects emergency medicine – while other clinicians and specialties may provide E/M services in non-facility settings (or a mixture of facility/non-facility), emergency physicians mainly perform evaluation and management (E/M) services that are exclusively provided in the facility setting. This reallocation treats a group's fixed costs as if the hospital has absorbed them simply because the care occurs in a facility – i.e., physician payment is reduced though the physician's costs have not changed.

Again, we share CMS' goal of preserving independent physician practice but believe this policy will have the opposite effect. Independent groups, especially smaller practices, will see shrinking reimbursement while their costs remain the same (or grow), which will exacerbate the pressures accelerating consolidation, ultimately putting ED coverage and timely access to lifesaving care at risk. We believe the intent of this policy can still be met with appropriate refinements, whether simply differentiating between those directly employed by the hospital or not (e.g., establishing a modifier to indicate employment) or at the very least excluding certain E&M and critical care services from the reduction.

We look forward to working together with Congress to identify substantive long-term reforms, and urge you to hold hearings and convene stakeholder roundtables to explore potential solutions that will guarantee the stability and security of the Medicare program, ensuring our nation's seniors have access to the high-quality care they need and deserve.

Once again, thank you for your attention to the issue of physician payment reform and for the opportunity to share our comments with you. We look forward to working together with you to develop potential solutions that will guarantee the long-term stability and security of the Medicare program, ensuring our nation's seniors have access to the high-quality care they need and deserve. Should you have any questions or need any additional information, please do not hesitate to reach out to Ryan McBride, ACEP Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,



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