



AMERICAN COLLEGE OF GASTROENTEROLOGY

11333 Woodglenn Drive, Suite 100, North Bethesda, Maryland, 20852-3071
P: 301-263-9000; F: 301-263-9025; Website: www.gi.org

**Statement for the Record of the American College of Gastroenterology
House Committee on Energy and Commerce, Subcommittee on Health
“Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms”
Wednesday, May 20, 2026**

The American College of Gastroenterology (ACG) appreciates the opportunity to provide this Statement for the Record concerning the House Committee on Energy and Commerce, Subcommittee on Health hearing entitled, “Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms.” This Statement for the Record specifically provides feedback on the recently released Medicare reimbursement reform discussion draft from members of the GOP Doctors Caucus and Congressional Doctors Caucus. We applaud Congress for taking steps to address the financial and regulatory burdens medical practices experience to improve access to patient care and improve the viability of independent practices.

Founded in 1932 and representing over 21,000 GI clinicians, ACG’s mission is to enhance the ability of our members to provide world-class care to patients with digestive disorders and advance the profession through excellence and innovation based upon the pillars of patient care, education, scientific investigation, advocacy, and practice management.

Section 101 – Modifying the Conversion Factor Updates Applicable to Physicians’ Services Under the Medicare Program

We appreciate that the discussion draft incorporates the Medicare Economic Index (MEI) into the conversion factor. We applaud Congress’s recognition that the status quo for physician payment is no longer sustainable. We also continue to urge Congress to consider providing the full MEI amount since costs continue to rise while payment for services our members provide continually decline. GI practices are facing rising practice costs, exacerbated by healthcare workforce shortages, as well as increasing medical device and equipment prices. Yet, reimbursement rates continue to decrease. The total percentage increase to the MEI since 2019 is 24 percent, while Medicare reimbursement for screening colonoscopy (CPT 45378) has decreased by a total of 15 percent over this same period. The widening gap between Medicare payments and the cost to provide care is acutely felt by practices in rural and underserved areas and a more comprehensive MEI update would help to ensure independent practices can continue to serve their patients.

Section 102 – Increasing Payments for Primary Care Services

We appreciate that the discussion draft includes increased payment amounts for primary care services. We urge that this funding should be used to support the delivery of evaluation and management services, including services for chronic GI conditions. We also appreciate that these additional funds would not be

subject to budget neutrality of the Medicare Physician Fee Schedule (PFS) but ask that Congress ensure this additional funding would not affect the relativity of the PFS, which could adversely affect non-evaluation and management services.

Section 202 – Payment Reform

We appreciate that Congress is recognizing the need for a new payment system and removing legacy Meaningful Use measures. To participate in the Merit-based Incentive Payment System (MIPS), eligible providers must meet the health IT thresholds in the “Promoting Interoperability” category. CMS’ latest estimate is that the cost per clinician for this category is \$287.¹ However, the start-up costs of investing in health IT are significant, and even the maintenance fees are much greater than CMS’ estimates. Moreover, the cost of electronic health record (EHR) software can vary widely depending on the factors discussed above, but for small practices with one to five physicians, EHR software typically costs between \$100 and \$600 per provider per month for cloud-based systems. In addition, on-premises solutions may require upfront costs ranging from \$15,000 to \$70,000, plus ongoing maintenance fees.²

It is critical that Congress consider these lessons learned from the current payment system. For example, Congress can consider requiring the Quality Reform Task Force to first review the burdens when assessing measures. In the *Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments* final rule (CY 2025 Medicare PFS final rule), CMS estimated roughly 38 hours of work per clinician was required for MIPS participation, at a cost of nearly \$7,800.^{3,4} However, available research suggests those figures are woefully low. One qualitative study revealed that physician practices across the U.S. spent more than 200 hours per physician on MIPS-related activities, at an average cost of \$12,811 to participate in MIPS in 2019.⁵

We are also concerned that since MIPS was established, CMS was given wide latitude to modify and implement the statutorily required elements of this program. As such, we encourage greater specificity regarding the new “cost containment” performance category and how this differs or interacts with the “resource use” performance category. Further, we ask that Congress consider how cost containment and resource use measures will be linked to the quality of a particular service. We believe this is a critically important part of advancing value-based care.

¹ 89 Fed. Reg. 97710 (Dec. 2024).

² DocVilla, *How Much Does EHR Software Cost? Discover Affordable EHR Pricing with DocVilla*, [https://www.docvilla.com/2024/08/16/how-much-does-ehr-software-cost/#:~:text=EHR%20Pricing:%20What%20to%20Expect,exceed%20\\$500%2C000%20in%20upfront%20costs](https://www.docvilla.com/2024/08/16/how-much-does-ehr-software-cost/#:~:text=EHR%20Pricing:%20What%20to%20Expect,exceed%20$500%2C000%20in%20upfront%20costs).

³ 89 Fed. Reg. 97710 (Dec. 2024); 90 Fed. Reg. 4926 (Nov. 2025).

⁴ In the CY 2026 Medicare PFS final rule, CMS did not outline any updates to its burden estimates due to the burden estimates not being affected by the policy provisions in the final rule. The applicable burden changes were submitted to OMB for approval under control number 0938-1314 (CMS-10621) and can be found here: <https://omb.report/icr/202509-0938-009/doc/162402700>.

⁵ 89 Fed. Reg. 97710 (Dec. 2024); JAMA Health Forum, *Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System* (May 2021), <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947>.

We also believe that Congress should consider how this new approach will impact small and rural practices. Assistance for small and rural practices are clearly not working. Medicare providers are exempted from MIPS if they fall below the low-volume threshold, which includes:

- Billing more than \$90,000 for Medicare Part B covered professional services;
- Treating more than 200 Medicare Part B patients; and
- Providing more than 200 professional services to Medicare Part B patients.

CMS also provides “special status” designations for rural and small practice providers.

While this is well-intended, data and experience reports show that participating in the MIPS program continues to strain small and rural practices.⁶ In the *Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program* final rule (CY 2026 Medicare PFS final rule), CMS estimates that in 2026, nearly 50 percent of solo practices and over 20 percent of practices with 2-15 providers will receive a payment cut for failing to successfully participate in the Quality Payment Program (QPP).⁷ The estimates are roughly the same for rural practices as well.⁸ The typical participating clinician cannot rely on MIPS to help offset PFS cuts because the average adjustment for 2025 was just 0.59 percent and the median was a meager 0.90 percent. This is lower than previous years, given the removal of the “exceptional” performance adjustment in 2024. Meanwhile, the MEI was 3.5 percent in 2025.⁹

The number of independent physicians in rural areas fell 43 percent from 21,956 in January 2019 to 12,467 in January 2024.¹⁰ Similarly, the number of medical practices in rural areas declined 11 percent from 30,000 in January 2019 to 26,700 in January 2024.¹¹ Therefore, we urge Congress to consider legislative solutions such as requiring CMS to stratify and calculate QPP bonuses by practice size and geographic area. The QPP experience reports clearly show that small and rural providers are at a competitive disadvantage to larger practices when trying to earn QPP bonuses. In addition, we urge Congress to consider additional legislative solutions such as expanding the low-volume thresholds and “special status” designations for small and rural providers to ease the burdens and challenges of participating in the QPP.

The federal government exempts small businesses with fewer than 50 employees from various employment and labor laws. ACG encourages Congress to follow the same precedent and exempt small

⁶ See Quality Payment Program, *Participation and Performance Data*, <https://qpp.cms.gov/resources/performance-data>.

⁷ 90 Fed. Reg. 4926 (Nov. 2025).

⁸ *Id.*

⁹ See <https://qpp.cms.gov/resources/performance-data>.

¹⁰ Becker’s Clinical Leadership, *Rural US loses 43% of independent physicians: 5 things to know*, <https://www.beckershospitalreview.com/quality/hospital-physician-relationships/rural-us-loses-43-of-independent-physicians-5-things-to-know/>.

¹¹ Becker’s Clinical Leadership, *The state of the physician workforce in 2025*, <https://www.beckershospitalreview.com/quality/hospital-physician-relationships/the-state-of-the-physician-workforce-in-2025/>.

and independent practices, or those in professional shortage areas, from certain regulatory/reporting requirements under this new model.

Finally, for more than 20 years, Congress has had to step in annually to protect the Geographic Practice Cost Index (GPCI) “floor,” ensuring that the physician work GPCI does not fall below the national average of 1.00. We ask that Congress consider reviewing the work GPCI inputs and data points, as salary costs and workforce shortages suggest that the rural practices are incurring costs similar to those of urban practices.

These types of exemptions and flexibility for smaller practices will allow them to become more efficient and competitive, supporting access to high-quality care across the country.

Section 302 – CMI Model Requirements

We urge Congress to address the duplicative quality reporting requirements that are especially burdensome for providers. We therefore request that Congress consider requiring CMS to implement a Center for Medicare and Medicaid Innovation (CMMI) model that would allow all Medicare providers to participate in the Medicare Advantage (MA) Quality Reporting Program instead of the QPP. There is no reason why physician practices need to devote resources to participating in two separate Medicare quality programs for fee-for-service (FFS) and MA. Congress should align and combine these two programs to ease practice management challenges and unnecessary burdens.

As it relates specifically to the annual reports to Congress on CMMI activities, we ask that Congress ensure all reports on a tested model include the costs and savings, the estimated administrative burdens to physician practices, and quality outcomes. For those models that have achieved savings, the quality of the care delivered, and any unintended consequences on practices are equally as important as the savings generated.

Section 303 – Report on Barriers to Participation in Value-Based Payment Models

We appreciate and support this section. ACG previously engaged with CMMI on developing models to support meaningful GI participation in value-based payment models, but these opportunities continue to be limited. In addition, we urge Congress to require in the same or different report, an assessment of the ability for specialties to participate in Accountable Care Organizations (ACOs) and Alternative Payment Models (APMs), especially if the specialty is a high cost to the ACO organization and threatens to achieve bonus payment thresholds.

Section 401 – Updating the Budget Neutrality Threshold

We appreciate that Congress is taking steps to address the antiquated budget neutrality threshold, which requires overall reimbursement spending to not exceed the baseline year of 1992. As a result, any increase to one specialty’s reimbursement means cuts to another’s – a “robbing Peter to pay Paul” paradox – after the budget neutrality threshold is triggered. While the overall size of the PFS continues to expand, the budget neutrality threshold remains stuck at \$20 million. Increasing this amount annually, and having it

increase by the cumulative increase in the MEI percentage, will help to ensure that PFS changes do not unfairly trigger budget neutrality redistributions.

We believe that the budget neutrality and lack of inflationary updates are the crux of the problem in the PFS. Despite the high spending requirements to the federal government, updating the threshold and providing annual, MEI-based updates to the overall PFS, are bold steps that we strongly support.

ACG appreciates your leadership in addressing the many challenges providers, especially GIs, face when delivering high quality healthcare services. We look forward to working with the Subcommittee to reduce financial and regulatory burdens to ensure increased access to care for patients and ensure a more healthy and viable business regulatory environment for private practice medicine. Please contact Brad Conway, VP Public Policy, Coverage & Reimbursement, at 301.263.9000 or bconway@gi.org to discuss further.