



**Statement of the American College of Surgeons
to the Committee on Energy & Commerce
Subcommittee on Health
United States House of Representatives
RE: Examining the Medicare Physician Fee Schedule, MACRA,
and Opportunities for Payment Reforms
May 20, 2026**

facs.org

CHICAGO HEADQUARTERS
633 N. Saint Clair Street
Chicago, IL 60611-3295
T 312-202-5000
F 312-202-5001
E-mail: postmaster@facs.org

WASHINGTON OFFICE
20 F Street NW, Suite 1000
Washington, DC 20001
T 202-337-2701
F 202-337-4271
E-mail: ahp@facs.org

On behalf of the more than 96,000 members of the American College of Surgeons (ACS), thank you for convening the hearing, “Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms.” The ACS remains committed to ensuring the highest quality of care for all surgical patients, including Medicare beneficiaries, and we appreciate the opportunity to discuss some areas within the Medicare reimbursement system that could be improved in order to ensure access to high-quality surgical care for all American seniors.

We thank Congress for its efforts to address short-term instability in the Medicare Physician Fee Schedule (MPFS) over the last few years, as well as the Health Subcommittee’s attention to broader reform of the Medicare Access and CHIP Reauthorize Act (MACRA). Federal policy should enable surgeons of all specialties, in all practice settings, and in all career stages, to provide the best possible care for their patients while leading full and productive personal and professional lives. The ACS is committed to working with Congress to stabilize the physician fee schedule as well as reform MACRA to better realize the goal of value-based care.

Identifying Structural Problems Within the Medicare Physician Payment System

Quality has been the cornerstone of the ACS since its founding more than 110 years ago, and the ACS continues to provide accreditation and verification programs, products, guidelines, and tools to improve surgical quality. But optimal quality, the centerpiece of the ACS’ mission, is not achievable without optimal access. Unfortunately, recent regulatory changes to the MPFS have systematically devalued surgical care, threatening patient access to critical services. In addition, long-term structural challenges persist within the payment system and with implementation of MACRA.

Instability within the MPFS threatens the viability of physician practices and erodes quality improvement efforts. Over the last few decades, Centers for Medicare & Medicaid Services (CMS) policies have resulted in broad and arbitrary cuts, repeatedly to the MPFS conversion factor, and more recently, to the work Relative Value Units (RVUs) and intra-service time for all non-time-based codes. These repeated cuts are often an unintended consequence of statutory budget neutrality requirements of the MPFS, which pit physicians against one another as resources must be taken away from certain physician services to finance others.

A zero-sum payment system is counterproductive as it forces all specialties to compete for increasingly scarce resources while failing to incentivize high-quality care or effective care coordination. The ACS is grateful to Congress for mitigating recent cuts by providing 2.5% conversion factor relief for 2026 as part of H.R. 1. However, if Congress does not act, this one-time fix will expire at the end of the year and create yet another cut to reimbursement on January 1, 2027.

Moreover, the MPFS remains the only Medicare payment system that is not indexed for inflation. Physicians saw their Medicare reimbursement decrease by 15.5% in real terms between 2001 and 2025 while practice expenses such as rent, equipment, staffing, and utilities have increased. Surgeons and other physicians have also seen an increase in financial pressures to meet new bureaucratic barriers such as increased use of prior authorization in Medicare Advantage.

In addition to these financial pressures, failures in the implementation of MACRA have hindered the transition to value-based care. Since the enactment of MACRA in 2015, the ACS has made significant investments to translate what we have learned about improving quality of care and outcomes into proposals to increase value for surgical patients. Our efforts have included:

- Early leadership and ongoing work in surgical alternative payment model (APM) development, including submission of one of the first Advanced APM proposals to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The ACS has continued to offer constructive feedback and advice to CMS and the Center for Medicare and Medicaid Innovation (CMMI) on how best to accommodate specialists eager to participate in value-based care;
- Development of the CMS *Age-Friendly Hospital Measure*, a novel programmatic quality measure finalized in the CMS Inpatient Quality Reporting (IQR) program that incentivizes patient-centered, goal-concordant, team-based care organized around the geriatric hospital patient; and
- Development of the *ACS CollaborATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients* measure to assess the quality of patients' shared decision-making for surgery in the ambulatory setting to improve patient-centricity, patient outcomes, and unnecessary care.

Yet today, many surgeons still struggle with the same barriers to improving outcomes and transitioning to modern payment systems that they did a decade ago:

- Surgeons were faced with a 2.5% reduction to work RVUs in 2026 in addition to reductions in facility-based practice expense RVUs earned for procedures performed outside an office setting;
- The combined effect of inflation and the absence of physician fee schedule updates to reflect rising practice costs has made care more expensive to deliver even as payment rates continue to decline;
- Most physicians in fee-for-service (FFS) are still evaluated based on measures that do not assess care delivered to their patients or the conditions they treat, meaning no information is available for improvement efforts or for patients and referring physicians to make care choices; and
- Many surgeons wishing to move beyond FFS will find few physician-focused APMs are available for them. Current options are largely mandatory and some limit the ability of interested parties to opt-in. This is compounded by the failure to test voluntary, physician-directed models approved by the PTAC.

MACRA was intended to fix problems in the previous reimbursement landscape and transition to a value-based care system. However, many structural barriers remain. Under current law, and assuming no additional cuts result from budget neutrality or other policy decisions, it would take decades for the MPFS conversion factor to return to the same amount it was in the year 2000. Over that same period, inflation will have significantly eroded the value of payments. Clearly, this is not tenable. The ACS is concerned that ongoing systemic challenges, coupled with the persistent devaluation of surgery within the MPFS, will jeopardize access to surgical services in the future.

I. **Addressing the Devaluation of Surgical Care**

Stop Implementation of CMS' Flawed Efficiency Adjustment

In order to ensure that Medicare patients maintain access to the full spectrum of health care services, Congress must first address the recent cuts to procedural codes that took effect January 1, 2026. This most recent cut disproportionately affects surgical and other procedural specialties and illustrates the broader structural issues that force physicians to fight over limited resources.

The latest action by CMS reduces the work RVUs and intra-service time for all non-time-based codes by 2.5% in 2026, with additional reductions expected every three years indefinitely. This “efficiency adjustment” is intended to address an incorrect assumption that non-time-based services become more efficient as the services become “more common, professionals gain more experience, technology is improved, and other operational improvements are implemented.”¹ In direct contradiction to this claim, a recent peer reviewed study published in the *Journal of the American College of Surgeons* analyzing more than 1.7 million operations, spanning 249 CPT codes and 11 surgical specialties, found that 90% of CPT codes had the same or longer operative times in 2023 compared to 2019.²

The policy from CMS assumes longitudinal efficiency for an individual physician and proposes the adjustment be applied in a cross-sectional manner to all non-time-based codes, including those that have been recently revalued. Adding to the flawed implementation of this policy, the 2.5% reduction was calculated using only the productivity component of the Medicare Economic Index (MEI), which is not a valid measurement of physician-specific productivity, given that the MEI is based on changes in economy-wide productivity and does not reflect physician work. While the MEI could be useful in accounting for the rising cost of care delivery, unfortunately, there is no automatic inflationary adjustment to account for these increased costs, based on MEI or otherwise, included in the MPFS, and the productivity component of the MEI on its own is meaningless.

This policy is based on the premise that services will continue to become more efficient indefinitely, and that all physicians experience the same rate of efficiency, which is flawed. While advances in medical technology and treatment protocols allow more patients to survive severe illnesses, these same patients often later require complex, high-risk procedural intervention. Highly experienced physicians may improve time efficiency, but undertake the most challenging cases, whereas newly trained or teaching physicians may treat less complicated patients but typically require more time. Valuation is based on time and complexity/intensity—not just time alone.

Further, a recurring reduction in work RVUs every three years will have severe consequences for physician compensation, even beyond direct reimbursement from the MPFS. Many physician employment contracts are based on work RVUs or total RVUs, meaning that reductions in these values will decrease physician compensation despite no reduction in actual work performed. The inability to anticipate the magnitude of RVU reductions introduces ongoing uncertainty, making it increasingly difficult to structure fair and sustainable employment agreements, while extending another layer of financial unpredictability for private practice and solo practitioners. The likely response to this instability may be further consolidation.

¹ 90 FR 32352

² Childers CP, Foe LM, Mujumdar V, et al. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. *J Am Coll Surg*. 2025.

For surgeons, this efficiency adjustment is not a technical coding issue. It is a direct payment cut layered on top of years of instability in the MPFS. It will disproportionately affect procedural and surgical care, including general surgery, where Medicare payment reductions already threaten access in communities facing shortages. **The ACS is grateful to Representatives Ron Estes and Tom Suozzi for introducing H.R. 7520, the Efficiency Adjustment Delay Act, to stop this cut and require CMS to provide clinically relevant data before implementing a one-time efficiency adjustment in the future. We urge Congress to include this legislation in boarder Medicare payment reform proposals.**

Appropriately Value Surgical Global Codes

The recent reduction applied to procedural codes is compounded by years of declining value of surgical global codes. Global codes bundle preoperative, intraoperative, and postoperative care into a single payment, limiting separate reimbursement for related services. In the calendar year (CY) 2021 MPFS final rule, CMS increased the values for office and outpatient Evaluation and Management (E/M) visits but failed to apply corresponding adjustments to the E/M services included within global surgical codes.³ Similarly, when the Agency approved increases to hospital inpatient and observation services for CY 2023, the corresponding adjustments within global surgical codes were not applied.

This deliberate departure from precedent in CYs 2021 and 2023 resulted in a disproportionate devaluation of global codes and created specialty-specific payment inequities that run contrary to Medicare statute. The ACS is concerned that by not incorporating this increased valuation of E/M codes into global surgical packages where similar services may be delivered as part of a patient's surgical case, the longitudinal care provided by surgeons is undervalued. **We continue to advocate for more accurate alignment between E/M valuation and the global codes to ensure high-quality surgical care is recognized.**

Reverse Facility-Based Practice Expense Changes

The CY 2026 MPFS final rule also included a reduction to indirect practice expense (PE) RVUs for facility-based services. This change is based on a flawed assumption that facility-based indirect PE payments may result in "double counting" when hospitals employ physicians, as some of these overhead costs may already be reflected in separate facility payments under the Outpatient Prospective Payment System. However, given that employed physicians never receive this facility fee, they are not the beneficiary of this perceived imbalance. Furthermore, CMS imposes this policy on all physician services furnished in the facility setting, regardless of the physician's employment status or practice structure. The result is a shift in reimbursement from the facility to the non-facility setting – estimated at -7% in facility settings and +4% in non-facility settings.

This change may result in increased payment for certain physicians billing office visits in the non-facility setting despite being employed by a hospital, in direct contradiction to CMS' stated intent. Additionally, it creates a perverse financial incentive for hospitals to consolidate by acquiring independent physician practices and shifting more services into the non-facility setting where higher payments may apply. Such a shift would accelerate the ongoing trend of market consolidation, reduce competition, and further inflate costs for patients. **The ACS believes that any savings CMS achieved by addressing perceived duplicate indirect PE payments should not be reallocated to non-facility PE RVUs. Instead, such savings should be redistributed via a budget neutrality adjustment to the MPFS conversion factor to**

³ Childers CP, Hu CY, Swisher SG, Wong SL, Chang GJ. Estimated Financial Impact of 2021 Office-Visit Work Relative Unit Updates on Surgical Global Periods. *JAMA Surg.* 2024;159(9):1087-1089.

maintain relativity across all specialties and settings, rather than inflating payments selectively for non-facility services.

Medicare Reimbursement Has Declined and Practice Costs Have Risen

Recent Medicare reimbursement changes must be understood in the broader context of physician payment system instability. The MPFS conversion factor has declined over the last several years, even as the cost of running a surgical practice has increased.

Calendar year	Medicare Physician Fee Schedule conversion factor	Notes
2021	\$34.89	Revised CY 2021 conversion factor after congressional action.
2022	\$34.61	Updated CY 2022 conversion factor; lower than 2021.
2023	\$33.89	Updated CY 2023 conversion factor after congressional relief.
2024	\$32.74 initially; later adjusted for part of the year	CMS listed the CY 2024 conversion factor as \$32.74 for Jan. 1–Mar. 8, with a later statutory update applying for Mar. 9–Dec. 31.
2025	\$32.35	Final CY 2025 conversion factor.
2026	\$33.57 for qualifying APM participants; \$33.40 for non-qualifying APM participants	CMS finalized separate 2026 conversion factors under current law. The conversion factors increased due to <i>temporary</i> congressional relief, pre-existing statutory adjustments, and budget neutrality effects of the efficiency adjustment.

From 2021 to 2025, the conversion factor fell from \$34.89 to \$32.35, a decline of approximately 7.3%. Even with the 2026 statutory increase, the non-qualifying APM conversion factor of \$33.40 remains about 4.3% below the 2021 level. And this increase masks reductions felt by many physician specialties affected by CMS policies including the efficiency adjustment.

That decline does not account for inflation, staff costs, rent, supplies, medical liability coverage, health information technology, compliance costs, or the cost of maintaining 24/7 surgical readiness. For general surgeons, who often provide emergency care, trauma coverage, endoscopy, abdominal surgery, cancer-related procedures, and essential backup for rural hospitals, this instability creates mounting pressure. Congress has repeatedly stepped in to mitigate scheduled cuts on a yearly basis, but temporary patches do not give surgical practices the predictability needed to recruit staff, maintain call coverage, invest in quality improvement, or remain financially viable in underserved communities.

II. **Stabilizing Medicare Reimbursement**

The ACS is committed to working together with Congress to ensure the stability of the MPFS through both short and long-term policy improvements. While 2026 is the first year where positive statutory updates are included in the MPFS, this positive adjustment is outweighed by years of devaluation. Current law provides a 0.25% conversion factor update for non-APM participants and a 0.75% update for qualified Advanced APM participants, still failing to adequately offset the effects of inflation and account for rising medical and staff costs. Without congressional action, continued cuts will challenge physicians to provide adequate services and high-quality care. Additionally, without an inflationary update for the MPFS, it is unlikely that future payments will keep pace with medical costs.

ACS supports building an update into the MPFS, comparable to other Medicare payment programs, to account for the effects of inflation on the cost of providing care to seniors as a starting point to create a more stable foundation for value-based care initiatives. This inflationary update should be separate and distinct from incentives for quality and from the budget-neutral Merit-based Incentive Payment System (MIPS) incentives. **One potential solution would be H.R. 6160, the Strengthening Medicare for Patients and Providers Act, introduced by Representatives Raul Ruiz, MD and Gus Bilirakis. This legislation would provide an inflationary update to the MPFS based on MEI.**

The impact of the lack of inflationary adjustments is further compounded by the overly strict nature of the budget neutrality trigger. The budget neutrality requirement in a system with no inflationary updates results in across-the-board cuts for any changes to the MPFS expected to increase expenditure by as little as \$20 million annually. This trigger amount has remained the same since its implementation in 1992. Updating the trigger for budget neutrality adjustments would help to ensure that comparatively minor changes to relative values or the addition of limited new service codes do not always require across the board cuts. **Congress, at a minimum, should amend 42 USC 1395w-4 (c)(2)(B)(ii) to increase the current \$20 million budget neutrality adjustment trigger and index it for inflation going forward. The ACS thanks Representative Greg Murphy, MD for introducing H.R. 8163, the Provider Reimbursement Stability Act of 2026, to reform the budget neutrality mechanism.**

III. **Improving MACRA to Ensure Meaningful Quality Measurement and Reduce Reporting Burden**

The passage of MACRA was necessary to remove the threat of the sustainable growth rate and combine the competing requirements of multiple measurement programs into a single program. However, over the past decade of implementation, it has become clear that the program lacks the flexibility to accommodate innovation in measurement science, technology, and modern approaches to incentivizing value-based care arrangements. Efforts to reform the program such as the move to MIPS Value Pathways have suffered from the same lack of flexibility, resulting in compromise solutions that fail to fully solve underlying problems with the system. If Congress seeks to improve Medicare physician payment, they must empower or direct the agency to break out of the constraints of the current program and rethink how we define and measure quality. Below are some suggestions based on the ACS' experience with verification and building quality programs.

Adopt Programmatic Measures

The ACS sees quality as a comprehensive program built around the patient, and inclusive of the entire team involved in providing care for patients with a given condition or diagnosis. The current model of individual,

disconnected measures is insufficient to achieve coordinated, patient-centered, high-value care and provides little actionable information for physician improvement or patient decision making when it is time to seek care. This is especially true in rural and under-resourced areas where regional shortages in surgeons and other care providers can lead to reduced access and fewer choices for care.

Most physicians in the current FFS system are evaluated on measures that do not reflect the care they deliver to patients or the conditions they treat. Further, the payment update associated with the reported data applies two years after the data has been reported. This means that no actionable, recent information is available for improvement or to help patients choose the best care for them. In contrast, the ACS has designed quality programs to overcome barriers faced by surgeons and other physicians who want to work together to coordinate and improve care. Based on these efforts and the more than 100-year history of the ACS working to improve the quality and value of care for surgical patients, the ACS believes addressing the shortcomings of traditional Medicare FFS payments will require new types of quality measures, facilitated by increased flexibility in participation and scoring options in MIPS. As described below, such a combination will improve care coordination and reduce surgical complications.

The ACS believes that we must refocus on the patient by incorporating shared decision-making and patient goal identification for goal-concordant care. To deliver on patient goals, it is critical that a verified quality program is in place, ensuring the right structures, processes, and personnel. All of this information should be transparently portrayed to help patients find and access such care. **ACS Verification programs, such as the Quality Verification Program (QVP) and the Geriatric Surgery Verification (GSV) Program, are examples of programs that align care teams around the needs of patients.** The framework used in these ACS Verification Programs is the basis of “programmatically measures,” which more accurately assess the ability of a system to provide high-quality care to patients. Programmatic quality measures do the following:

- Align multiple structures, processes, and outcome measures, including patient-reported outcomes;
- Focus on shared decision-making and goal concordant care;
- Target condition or population specific care;
- Apply to multiple quality domains;
- Follow the continuum of care; and
- Create actionable quality improvement information for care teams.

Our experience with programmatic measures exhibits applicability to diverse care settings, limited burden on care providers, and demonstrably better results. Applied correctly, programmatic measures will address the quality gaps created by the current measures and ensure surgical care is measured appropriately.

Expand Scoring Options

The ACS also supports greater flexibility in how physicians and teams are measured. Under the current MIPS framework for example, we have supported expanding the existing facility-based scoring option by including more facility settings and reporting programs and applying it to all four MIPS categories (to include Promoting Interoperability and Improvement Activities, in addition to Quality and Cost as currently

in statute). Allowing for facility-based scoring and measurement in an FFS framework is in line with the ACS perspective on programmatic quality programs and is more closely aligned with how patients experience care.

A framework of shared measurement between facilities and physicians could greatly aid in care-coordination, especially when coupled with programmatic measures such as the *Age-Friendly Hospital Measure* included in the IQR program. Such a change should not appreciably increase costs because physicians would continue to be updated through the largely budget neutral MIPS program.

The ACS developed programs like GSV and QVP have demonstrated marked improvements in patient care in trauma, cancer, bariatric surgery, geriatric surgery, and other areas, all of which involve the clinical team and facilities coming together to improve the delivery of care. Alignment with facility reporting is critical for care centering the patient. **We believe a voluntary expansion of facility-based scoring to additional physicians, sites of service, and to all MIPS categories would be an important incremental step toward better coordinated value-based care. It would also greatly reduce reporting burden while creating the environment necessary for meaningful quality programs to be recognized and incentivized in the FFS payment environment.**

Engage Physician Stakeholders in APM Development

The ACS supports building a more modern care environment for patients, rewarding value and innovation. Medicine should be moving steadily toward a system that truly rewards the value of care provided rather than data entry that may have little relevance to the patients being treated, while ensuring access to high-quality care across all settings. This could partially be achieved through testing and expansion of APMs developed by and for specialists.

CMMI has recently taken important steps to expand APM opportunities for specialists such as the newly implemented Transforming Episode Accountability Model, which focuses on five categories of surgical care, and the upcoming Long-term Enhanced Accountable Care Organization (ACO) Design model, which includes CMS-Administered Risk Arrangements specifically to make it easier for ACOs to bring specialists into value-based care. These represent steps in the right direction but could be improved through greater outreach to specialty societies and physicians treating the affected patient groups. In addition, limiting innovation to CMS designed models is slowing progress. **Congress should encourage innovation by incentivizing the testing and implementation of physician-developed, value-based payment models. Models developed by subject matter experts such as specialty societies will be better structured to provide and utilize timely, actionable data and allow physicians to improve care.**

Congressional Action is Needed to Reform Medicare Payment: In Summary

Medicare physician payment reform is urgently needed. While the value-transformation is underway, it could greatly benefit from improving the foundation of the physician fee schedule as well as efficient investments in the partnership between CMS and stakeholders interested in improving the way quality is measured and incentivized. Congress has the opportunity to address recent misguided changes to physician reimbursement, as well as provide CMS with direction, flexibility, and additional authority to help achieve the goal of improving value. The ACS proposes the following specific action items for Congress to consider:

- Stop the 2.5% efficiency adjustment enacted in 2026 and future pending cuts;

- Implement an update mechanism in the MPFS to account for inflation. This will create a stable base from which physicians can make the leap to models involving risk;
- Eliminate the MPFS budget neutrality requirement or increase the trigger threshold and index it annually to account for inflation;
- Direct CMS to partner with stakeholders to test physician-developed APMs, such as those recommended previously by the PTAC; and
- Create flexibility for shared measurement and accountability in MIPS, such as through expansion of facility-based scoring.

It is critical that Congress take steps to stabilize the Medicare physician payment system, build upon MACRA's vision of value-based care, and ensure the appropriate valuation of surgical services. Federal policy should support all physicians to provide the best care for their patients in the most appropriate setting, not pit specialties against one another, or perversely incentivize consolidation. Medicare reimbursement must account for the rising cost of providing care, the increasing medical complexity of an aging population, and the essential role that physicians play in their communities.

Surgeons are committed to being part of the solution, and the ACS looks forward to continuing to work with Congress to advance these critical and necessary reforms. Thank you for convening this important hearing and for the Subcommittee's commitment to our shared goal of ensuring access to high-quality, affordable care for all Americans.

For questions or additional information, please contact Emma Zimmerman with the ACS Division of Advocacy and Health Policy at ezimmerman@facs.org.