

Oct. 5–7

AMA Advocacy in Action Workshop



Advocating for Medicare Reform: The Patients First Act

Medicare is a federally funded health insurance program for those 65+ and/or those with certain disabilities. Established in 1965 under the Social Security Administration (SSA), Medicare insures 65 million people. Traditional Medicare includes Parts A and B, which covers costs for inpatient hospital stays and medical costs, respectively. Alternatively, Medicare enrollees can purchase Plan C, also known as Medicare Advantage (MA), instead of traditional Medicare. MA bundles Parts A, B, and D (prescription drug coverage) under one plan and is also privately insured.¹

Issues with Physician Reimbursement

In 1992, the Medicare Physician Fee Schedule (PFS) was introduced as a means to annually adjust physician reimbursement rates to better reflect changes in healthcare costs, provider responsibilities, and more.² Overtime, the PFS has lagged behind rising healthcare costs, resulting in overall physician pay cuts of about 33 percent since 2001.³ Despite continuous advocacy efforts from the AMA and other health organizations, CMS has yet to institute an annual inflationary update for Medicare physician reimbursement as informed by the Medicare Economic Index (MEI), a measure of practice cost inflation developed in 1975 to estimate annual changes in physicians' operating costs and establish appropriate Medicare physician payment updates.⁴ Physicians remain the only Medicare provider type that does not receive an annual payment update tied to inflation. This growing gap between payment updates and inflation in their costs has already forced many practices, including small, rural, and independent practices, to consolidate or limit the number of Medicare patients they can treat.⁵ Left unaddressed, this erosion threatens timely access to care for millions of Medicare patients.

Further exacerbating cuts to physician Medicare reimbursement is the budget neutrality threshold. Enacted with the PFS in 1992, CMS must not exceed more than \$20 million in spending for any PFS payment updates.⁶ This means that physician reimbursement increases for specific services must be offset by cuts to other aspects of care if the total spending exceeds the budget neutrality threshold.⁷ This threshold has remained at \$20 million since 1992, meaning the threshold does not accurately reflect changes in inflation and health spending.

Struggles with Implementing Medicare Value-Based Incentive Programs

Medicare has instituted multiple value-based and quality reimbursement measures, such as the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). These programs were created as a result of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015.⁸

The MIPS program incentivizes physicians with payment bonuses if they achieve certain metrics related to quality of care and cost-savings. While created with the intention of improving patient care and health spending, MIPS have increased physician costs and workload, owed to the documentation required to demonstrate that a provider is meeting MIPS competencies.⁹ In addition, while 87 percent of MIPS-eligible physicians avoided a penalty or earned a bonus for the 2022 fiscal year, the 13 percent who received penalties were disproportionately from small and/or rural practices.¹⁰ Such inequities result in financial disparities for physicians serving in critical access gaps.

APMs are another value-based reimbursement structure intended to incentivize physicians to shift away from fee-for-service payment models. As such, APMs reward physicians for participating in value-based alternative payment models such as Accountable Care Organizations (ACOs).¹¹ Medicare-reimbursed physicians are eligible to become Qualifying APM Participants (QPs) if they have a certain percentage of patients or payment volume assigned to an Advanced APM. However, many physicians, especially specialists, struggle to meet the percentage

thresholds to become a QP despite interest in participating in an alternative payment model.¹² Such thresholds can thus disincentivize physicians from participating in APMs.

Legislative Solutions

In order to increase access to and quality of care for Medicare patients, legislative reforms are needed to revise Medicare physician reimbursement models to meet the economic reality of the current U.S. healthcare system. Introduced by the Doc Caucus chairs Reps. John Joyce (R-PA), Greg Murphy (R-NC), and Kim Schrier (D-WA), the Patients First Act (H.R. 9693) attempts to do just that. More specifically, the Patients First Act provides necessary updates to Medicare physician reimbursement by:

- Establishing a permanent annual payment update linked to the MEI, built into the baseline, so that Medicare payment more closely tracks increases in the cost of running a practice.
 - The bill also uses new money to extend and increase the work geographic practice cost index (GPCI) through 2031, raising work values in every locality nationwide. These increases are expected not only to increase Medicare payment rates but also to help physicians whose compensation is tied to the work relative values.
- Establishing a pilot 5-year hybrid payment demonstration for independent primary care practices, fully funded and exempt from budget neutrality so as not to reduce payments for any other specialty.
- Replacing the MIPS program with the Patient Outcome Improvement National Tabulation System (POINTS), which will determine quality metrics through a physician-majority Quality Care Reform Task Force.
 - POINTS also reduces maximum penalties during and after the transition to this new system and creates a new Care Efficiency category, rewarding physicians for the Medicare savings they generate by preventing avoidable hospitalizations and complications of chronic disease.
- Freezing the Qualifying Participant threshold at 50 percent for three years, authorizing the Secretary to set lower thresholds, and requiring reports on the barriers specialists face in joining APMs, which will preserve meaningful incentives for physicians to transition into value-based care.
- Creating a correction process requiring the Centers for Medicare & Medicaid Services to reconcile utilization misestimates so physicians are no longer penalized indefinitely for estimation errors unrelated to the care they provide, and raising the budget neutrality threshold from \$20 million to \$57.64 million in 2028 with regular indexing thereafter.

Taken together, the Patients First Act addresses the four core reforms the AMA and organized medicine have sought for more than a decade: automatic annual inflation-based payment updates, modernized budget neutrality policies, simplified and clinically relevant quality measurement, and greater opportunities for physicians to participate in alternative payment models. In doing so, it aligns squarely with the Characteristics of a Rational Medicare Physician Payment System, the framework endorsed by more than 120 state medical associations and national specialty societies, and advances each of that framework's three overarching goals—ensuring financial stability and predictability, promoting value-based care, and safeguarding access to high-quality care for the patients who depend on small, rural, and independent practices. The AMA has written an authored letter to the House in support of such legislation.

- The Patients First Act H.R. 9693 was introduced by Reps. John Joyce (R-PA), Greg Murphy (R-NC), and Kim Schrier (D-WA).

ACTION REQUESTED

Coordinate a sign-on letter for students from your medical school urging your Representatives to cosponsor:

- H.R. 9693, the Patients First Act, in order to bring needed reforms to Medicare so patients can access the care that they need.

Strengthen Graduate Medical Education

Contact your representatives to co-sponsor the REDI, SPARC, and Resident Physician Shortage Reduction Acts.

Endnotes

1. Soc. Sec. Admin., Medicare (Pub. No. 05-10043, Jan. 2025), <https://www.ssa.gov/pubs/EN-05-10043.pdf>
2. Am. Med. Ass'n, Timeline, Fix Medicare Now, <https://fixmedicarenow.org/history>
3. Am. Med. Ass'n, Medicare Physician Updates Compared to Inflation in Practice Costs (2001–2025) (updated Jan. 2025), https://fixmedicarenow.org/sites/default/files/2025-01/Medicare%20Gap%20Chart_2025.pdf
4. Am. Med. Ass'n, Medicare Basics: The Medicare Economic Index (June 2024), <https://www.ama-assn.org/system/files/medicare-basics-medicare-economic-index.pdf>
5. Am. Med. Ass'n, Letter to the U.S. House of Representatives in Support of the Patients First Act (H.R. 9693TA) (July 22, 2026), <https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfj.zip/2026-7-22-Letter-to-House-re-HR-9693TA-Support-for-Patients-First-Act-v2.pdf>
6. Am. Med. Ass'n, Why Bipartisan Agreement on Medicare Payment Reform Means So Much (June 30, 2026), <https://www.ama-assn.org/about/leadership/why-bipartisan-agreement-medicare-payment-reform-means-so-much>
7. *Id.*
8. Am. Med. Ass'n, Timeline, Fix Medicare Now, <https://fixmedicarenow.org/history>
9. Am. Med. Ass'n, Medicare Basics Series: Merit-Based Incentive Payment System (MIPS) (updated Oct. 9, 2023), <https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-basics-series-merit-based-incentive-payment-system>
10. Am. Med. Ass'n, It's Time to Revamp Medicare's Broken MIPS Program (July 8, 2024), <https://www.ama-assn.org/practice-management/payment-delivery-models/it-s-time-revamp-medicare-s-broken-mips-program>
11. Am. Med. Ass'n, Medicare Basics Series: Advancing Value-Based Care with Alternative Payment Models (updated June 30, 2025), <https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-basics-series-advancing-value-based-care-alternative>
12. *Id.*