Protect access for America's seniors

Enact Medicare physician payment reforms

Stable and adequate Medicare payments are essential to protect seniors' access to care and support the physicians who treat them. Yet, for decades, the Medicare Physician Fee Schedule (MPFS) has faced growing instability, driven by four key challenges.

Key challenges

- **No inflationary updates**
  Since 2001 Medicare physician payments—when adjusted for practice cost inflation—have dropped 33%. Other Medicare providers (e.g., hospitals, Medicare Advantage) receive statutory based inflationary updates, but physicians are excluded.

  Congress provided a one-time 2.5% update for 2026 in the One Big Beautiful Bill Act, but this temporary fix disappears in 2027—returning physicians to inadequate 0.25%–0.75% updates that fall far below projected practice cost growth.

- **Flawed budget neutrality rules**
  Arbitrary cuts triggered by inaccurate Centers for Medicare & Medicaid Services (CMS) projections permanently reduce payments. For example, the G2211 "Inherent Complexity" code associated with Evaluation and Management services caused a $1 billion annual loss to the MPFS. Congress has repeatedly spent billions on short-term patches, creating financial uncertainty and instability in the Medicare program.

- **Merit-based Incentive Payment System (MIPS) burdens**
  MIPS adds costly, complex reporting with little link to improved outcomes. Penalties disproportionately fall on small, rural and solo practices while large systems are rewarded simply for compliance.

- **Limited alternative payment model (APM) options**
  Many specialties and rural physicians lack access to alternative payment models. The continued threat of APM incentive payments expiring automatically and statutory requirements of higher revenue qualification thresholds further slow progress toward value-based care.

By the numbers

33% decline in physician payment rates since 2001 (after inflation).

ONE BILLION lost annually due to flawed CMS projections (G2211 code).

29% of small practices and 50% of solo practitioners penalized under MIPS in 2024.

2.5% temporary update for 2026—expires in 2027.

Congressional action needed

To stabilize Medicare payments and protect seniors' access to care, Congress must:

1. **Provide annual inflationary updates tied to practice costs**
   Permanently tie Medicare payments to the Medicare Economic Index (MEI) to reflect real practice costs.
2. **Fix budget neutrality**
   Raise the threshold and require CMS to prospectively correct conversion factor cuts when projections associated with newly unbundled codes that have a utilization assumption are wrong.
3. **Restructure MIPS**
   End the "tournament" penalty/bonus model and ensure timely data feedback.
4. **Expand APM options**
   Extend the APM incentive payment, freeze thresholds, and develop more specialty-specific and rural models.

Action request

Urge your senators and representative to support legislation that:

- Provides annual inflationary updates tied to practice costs
- Reforms budget neutrality
- Improves MIPS
- Expands APM options

These reforms are essential to preserving patient access to care by stabilizing physician practices and thereby ensuring America's seniors have timely access to high-quality care.

Reducing prior authorization burdens

Prior authorization—or the practice of insurance companies reviewing and potentially denying coverage of medical services and pharmaceuticals prior to treatment—remains a principal frustration for physicians and jeopardizes patient care. According to a 2024 American Medical Association survey, physicians complete an average of 39 prior authorizations per week. The administrative burden has become so acute that 40% of physician survey respondents hired staff to work exclusively on prior authorization requirements. Most alarming, however, is the fact that more than 1 in 4 physicians (29%) report that prior authorization requirements have led to a serious adverse event for a patient in their care—including hospitalization, permanent bodily damage, congenital anomalies/birth defect, or even death.

The AMA believes that medically necessary clinical services and prescriptions covered by health insurance plans should be administered without delay. Prior authorization undermines physicians' medical expertise and leads to considerable delays in patient care. According to the 2024 AMA survey, 93% of physicians reported care delays associated with prior authorization, and 82% said these requirements can lead to patients abandoning treatment.

In addition to poor clinical outcomes, prior authorization leads to increased costs due to higher overall utilization of health care resources. For example, 77% of the 2024 AMA survey respondents reported ineffectual initial treatments delivered to patients due to "step therapy (i.e., insurer mandated "fail first" requirements)," 73% reported patients requiring additional office visits, 47% reported the need to advise patients to seek urgent care or the emergency department, and 33% reported hospital admittance for patients all stemming from prior authorization. The fiscal realities raise serious questions about the overall value proposition of prior authorization.

Finally, data from the federal government further confirms the negative impact of prior authorization processes within Medicare Advantage (MA). More specifically, an April 2022 Department of Health and Human Services Office of Inspector General Report concluded that 13% of prior authorization requests that were ultimately denied for MA patients would have been approved for these same beneficiaries had they been covered under traditional Medicare. The same study also found that 18% of payment requests that were denied by MA plans actually met standard Medicare coverage and billing rules.

Improving prior authorization in Medicare Advantage

Congress remains focused on limiting the negative impact of prior authorization requirements via H.R. 3514/S. 1816, the Improving Seniors' Timely Access to Care Act. This bill reduces physician administrative burden and unnecessary delays in patient care by facilitating the expansion of electronic prior authorization solely for "items and services" in MA. The legislation, which currently has a majority of the House of Representatives (254) and a super majority of the Senate (66) as cosponsors, incorporates all major elements of a 2018 consensus statement developed by leading physician, hospital, medical group, health plan and pharmacy stakeholders.

More specifically, the bill would:

- Require MA plans to implement electronic prior authorization programs that adhere to newly developed federal standards and are capable of seamlessly integrating into electronic health systems (vs. proprietary health plan portals)
- Mandate that plans report to the Centers for Medicare & Medicaid Services (CMS) on the extent of their use of prior authorization and the rate of approvals and denials
- Provide a pathway for CMS to study and institute real-time decisions for routinely approved items and services
- Clarify CMS' authority to establish timeframes for electronic prior authorization request approvals, including expedited deadlines for emergent services
- Require HHS and other agencies to report to Congress on program integrity efforts and other ways to further improve the electronic prior authorization process

The Improving Seniors' Timely Access to Care Act passed the House of Representatives by voice vote in the 117th Congress but did not advance in the Senate due to a high Congressional Budget Office (CBO) "score" estimating significant implementation costs. H.R. 3514/S. 1816 addresses the issues that led to the high score, and its sponsors expect the CBO to estimate that the legislation will have no fiscal impact.

Congressional request

- Urge your representative/senators to cosponsor H.R. 3514/S. 1816, the Improving Seniors' Timely Access to Care Act, bipartisan, bicameral legislation that reduces the burden of prior authorization within Medicare Advantage and promotes patient access to timely, high-quality care.
- If your representative or senator has already cosponsored H.R. 3514/S. 1816, simply thank them for their support and urge them to work with bipartisan, bicameral leaders to expeditiously pass this legislation in the 119th Congress.
    - Reps. Mike Kelly (R-Pa.), Suzan DelBene (D-Wash.), Ami Bera, MD (D-Calif.), and John Joyce, MD (R-Pa.) introduced H.R. 3514, while Sens. Roger Marshall, MD (R-Kan.) and Mark Warner (D-Va.) are the lead sponsors of S. 1816.

To access the AMA's prior authorization research and advocacy resources, visit https://fixpriorauth.org/.

Protecting access to care in Medicaid

Recent changes to Medicaid financing enacted in the One Big Beautiful Bill Act (OBBBA) legislation are now moving into the implementation phase. While these policies remain controversial, physicians are focused on how implementation affects patients and providers, including vulnerable populations.

The American Medical Association, state medical associations, and physician leaders are engaging with state Medicaid agencies to ensure these changes are implemented to minimize disruptions to care and protect access in medically underserved communities.

Please encourage Congress to:

- Provide strong oversight of implementation to ensure patient access is not compromised
- Support state flexibility and technical assistance to smooth transitions and reduce provider instability
- Monitor patient and provider impacts, especially in rural and safety-net settings

AMA recommendations on Medicaid implementation (OBBBA)

- **Maximize automatic, data-driven processes to reduce administrative burden** by using ex parte processes and existing data sources to conduct renewals and verify eligibility before requiring beneficiary paperwork, and by preventing eligible patients from losing coverage.
- **Provide safeguards, flexibility and technical support to states** to minimize procedural errors and avoidable coverage losses.
- **Maintain transparency through monitoring and public reporting;** continue publishing renewal and disenrollment data to identify system challenges early and promote accountability.
- **Coordinate overlapping eligibility requirements and communications;** align more frequent renewals with new community engagement requirements aimed at ensuring patients receive timely, accessible communications through multiple channels.

How the AMA is supporting state-level Medicaid implementation

- Developing advocacy resources with analysis of statutory and regulatory changes, implementation timelines and key state decision points.
- Providing technical assistance and advocacy support to state and specialty medical associations.
- Convening Federation partners to share implementation strategies, data and best practices.

The AMA has launched a webpage with additional information on OBBBA and related advocacy efforts: ama-assn.org/OB3

The AMA remains committed to working with federal and state policymakers to ensure Medicaid implementation protects patient access to care and supports the physicians who serve Medicaid communities.