AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Brett Guthrie
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
348 Cannon House Office Building
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Pallone:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to share our perspective on the Committee on Energy and Commerce Budget Reconciliation text.

The AMA strongly supports section 44304 of the Committee's recommendations, which provides a positive modification to the conversion factor under the Medicare physician fee schedule. Physician practices have faced a 33 percent loss in purchasing power since 2001, severely straining their sustainability. Congress has adopted several temporary physician payment updates to help address steep pay cuts that took effect starting in 2021, but each of these updates led to a steep cliff as the payment update expired and reverted to the reduced payment rate as if there had been no legislative provision at all. Section 44304 provides the first Medicare physician payment update that is permanently built into baseline Medicare rates since the passage of the Medicare and CHIP Reauthorization Act (MACRA) in 2015. As recommended by the Medicare Payment Advisory Commission, it links the Medicare update to inflation in medical practice costs as measured by the Medicare Economic Index (MEI). The proposed 2026 update, 75 percent of MEI, is significantly higher than any of the annual physician payment updates in MACRA. It has been decades since Medicare physician payment updates were linked to the MEI and the AMA strongly supports it.

Under current law, the update for most physician practices will lead to rates being below their 2024 levels at the end of the budget window in 2035. It is absolutely vital that this issue be addressed. It should come as no surprise that physician ownership of their practices has collapsed dramatically over the past quarter century. In 2001, 61 percent of physicians were owners. By 2016, fewer than half of physicians had ownership stakes in their practices, and since 2018 more physicians are employees than owners. Physicians should not be forced to leave community-based practice because it is not financially sustainable, and addressing this erosion is essential to strengthening the Medicare program and protecting patient access to care.

We further view these provisions as a foundational step toward comprehensive Medicare physician payment reform in the 119th Congress. Ensuring regular, adequate payment updates is vital to maintaining practice stability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries—particularly in rural and underserved communities. Medical practices in the most rural locations treat four times as many Medicare patients as metropolitan practices. The AMA remains

committed to working with Congress to achieve lasting reforms so patients and physicians have the Medicare program they deserve.

The AMA is very pleased to see the inclusion of language requiring additional levels of transparency from pharmacy benefit managers, as well as efforts to constrain pharmacy benefit managers (PBM) compensation in ways that serve to increase costs to patients. The AMA has consistently expressed concern regarding the opaque way PBMs operate and the impact PBM business practices have on access to medically necessary drugs for patients. We have also been deeply concerned about the impacts of the business practices of both prescription drug manufacturers and PBMs on costs to both patients and the health care system at large. As such, we strongly support efforts to mandate greater transparency regarding the business practices of PBMs. This lack of transparency has made it difficult to understand exactly how PBMs operate and the nature of their contracting with manufacturers and health plans and in turn has made it difficult to determine appropriate legislative or regulatory action to limit their continued ability to manipulate the system for their own financial gain.

The AMA would also like to share our views on proposed changes to the Medicaid and Children's Health Insurance Program (CHIP) programs included in the reconciliation legislation. As physicians, we know that Medicaid is a vital component of America's health care infrastructure, providing health insurance coverage to millions of patients and serving as a critical safety net for children, pregnant and postpartum women, seniors, and people with disabilities and serious health conditions. Medicaid coverage is associated with improved long-term health, lower rates of mortality, better health outcomes, fewer hospitalizations, better educational outcomes, and greater financial security.[1] Medicaid is an indispensable source of coverage for maternal health services, covering over 40 percent of all births in the United States, including almost 50 percent of births in rural areas.[2] In many communities Medicaid is a major source of health insurance coverage or, in some cases, the primary payer.[3] For the physician practices and other health care providers who serve these communities, Medicaid payments are a crucial source of funding without which they might be unable to continue to operate, jeopardizing access to care in those communities and in rural areas in particular. For all these reasons, the AMA has a strong interest in ensuring that Medicaid remains a reliable source of health insurance coverage for low-income Americans and other vulnerable patients.

The AMA commends the Committee on the inclusion of section 44302, which streamlines the enrollment process for eligible out-of-state providers under Medicaid and CHIP and will increase the ability of children enrolled in Medicaid and CHIP to receive the care they need from the appropriate providers, even if those providers are located in a different state. However, after reviewing the proposed changes to the Medicaid and CHIP programs, we note the potential for unintended consequences that could affect patients, rural and underserved communities, and the providers who serve them. Medicaid and CHIP—like any large health insurance program[4]—lose money to waste, fraud, and abuse, and the AMA is supportive of legislative efforts to address these program integrity issues in a targeted fashion. However,

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[1] Benjamin D. Sommers, Katherine Baicker & Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions." 367 NEJM 11, 1025-34 (Sep. 2012); Henry J. Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight in the Evidence" (Aug. 2013); Alisa Chester & Joan Alker, Georgetown University Health Policy Institute Center for Children and Families, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid" (Jul. 2015).

[2] https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid.

[3] https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.

[4] https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/.

changes that would result in reductions in Medicaid and CHIP funding, procedural changes that may lead to coverage disruptions for otherwise eligible patients, or new obstacles to physicians and other providers participating in Medicaid and CHIP would go against the long-standing policy of the AMA that any Medicaid reform should avoid jeopardizing patient access to health care.

With respect to changes that could result in the denial or loss of coverage under Medicaid or CHIP for eligible patients, the AMA is particularly concerned with sections 44101, 44102, 44108, and 44141. These provisions create additional administrative burdens for patients and could result in more patients being denied or losing coverage under Medicaid or CHIP for failing to comply with administrative requirements, despite meeting all substantive criteria for eligibility.

The AMA understands that robust processes are necessary for program integrity, but we recommend minimizing administrative complexity to help eligible patients enroll and maintain coverage under Medicaid and CHIP. Administrative hurdles in these two safety net programs are a proven barrier to eligible individuals enrolling for coverage, especially given that of the estimated 25.3 million uninsured Americans in 2023, 6.3 million were eligible for Medicaid or CHIP but not enrolled, often due to administrative barriers.[5] The proposed changes may increase the risk of wrongful denials or disenrollments, disrupting patients' access to care and potentially affecting the continuity of care physicians strive to provide. To limit patient churn and help ensure continuity of care, AMA policy supports 12-month continuous eligibility in Medicaid and CHIP.

With respect to the community engagement requirements established under section 44141, the AMA appreciates the policy's goal of lifting people out of poverty by incentivizing stable employment. However, as physicians, we are particularly concerned about the potential for coverage losses and disruptions in continuity of care. Work requirements have in some instances contributed to fluctuations in coverage in and out of the program. Experience from state-level programs suggests that work requirements can be administratively complex and have not consistently achieved improved employment outcomes.[6] This experience supports AMA policy that opposes work requirements due to serious concerns about the impact that such proposals may have on access to health care for patients who are otherwise eligible for coverage under Medicaid.

The group most affected by the new work requirements is the Medicaid expansion population. Over 90 percent of adults enrolled in Medicaid through the expansion pathway either already work or meet the criteria for exemption from the requirement, such as being the parent of a dependent child.[7] Evidence from work requirement programs implemented in multiple states shows that the administrative burdens of demonstrating compliance with work requirements can result in coverage interruptions even among

[5] https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured; https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/.

[6] https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment.

[7] https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work; https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

individuals who are working or otherwise exempt.[8] While the implementation challenges associated with work requirements and the resulting losses in coverage for working beneficiaries are universal, they are even more pronounced in rural areas.[9]

Adding complexity to the Medicaid expansion pathway by increasing administrative burdens for expansion patients could have substantial consequences. The expansion option provides an essential pathway to health insurance coverage for millions of low-income Americans (in 2025, the income eligibility threshold for the expansion pathway was $21,597 for a single-person household). Since it was first implemented in 2014, Medicaid expansion has been adopted by 40 states (including seven states that adopted expansion pursuant to a voter referendum) and the District of Columbia[10] and has filled a gap in the health care system by providing coverage to patients without access to employer sponsored insurance or the ability to pay for private insurance. The popularity of Medicaid expansion continues to grow, with new states reinforcing their commitment as recently as March 2025, when Montana voted to make its Medicaid expansion permanent.[11]

Medicaid expansion has been shown to have significant positive benefits for low-income patients, with many studies demonstrating improvements in expansion states in health care coverage, access, utilization, and mortality.[12] Medicaid expansion has played an important role in fighting America's opioid epidemic, providing much-needed treatment and coverage of lifesaving medications for opioid use disorder to millions of beneficiaries with substance use disorders and creating significant savings through decreased hospital and emergency department utilization.[13] Medicaid expansion has also contributed to substantial improvements in maternal health outcomes in the United States, with research indicating that Medicaid expansion is associated with a 17 percent decrease in hospitalization rates in postpartum women.[14] The expansion has also been an important source of coverage for individuals with chronic health conditions, with 44 percent of expansion enrollees suffering from at least one chronic condition.[15]

For all these reasons, we would urge the Committee to reconsider the proposed changes that create additional administrative barriers for all Medicaid and CHIP patients. To the extent additional program integrity measures are necessary, we would recommend that the Committee consider adding safeguards to ensure that such measures do not result in eligible patients losing coverage under Medicaid and CHIP.

Another change that we note could impact timely access to care for some patients is the modification to retroactive coverage requirements contained in section 44122. Under current law, states are required to

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[8] https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care; https://familiesusa.org/wp-content/uploads/2025/03/Medicaid-Work-Reporting-Requirements-Fact-Sheet.pdf; Benjamin Sommers, Anna Goldman, Robert Blendon, et al., Medicaid Work Requirements—Results from the First Year in Arkansas, 381 New England Journal of Medicine 11, 1073-82.

[9] https://healthlaw.org/wp-content/uploads/2025/04/ParkerNewton_MedicaidWorkRequirementsUndermineRuralHealthcare_04042025.pdf.

[10] https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

[11] https://www.mtpr.org/montana-news/2025-03-28/governor-signs-medicaid-expansion-renewal-into-law.

[12] https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not; Sarah Miller, Norman Johnson, Laura R Wherry, "Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data," The Quarterly Journal of Economics, Volume 136, Issue 3, August 2021, Pages 1783–1829.

[13] https://ccf.georgetown.edu/2025/02/19/how-medicaid-helps-people-with-substance-use-disorders.

[14] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00819.

[15] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/.

provide retroactive Medicaid and CHIP coverage for the three months preceding the month in which an eligible patient submits their application for assistance under the program. The proposed change would reduce this requirement to one month of retroactive coverage. To ensure that patients receive the care they need when they need it, AMA policy supports retroactive coverage for low-income patients to the time at which an eligible patient seeks medical care.

The proposed changes to Medicaid and CHIP also include additional provider screening requirements. While current regulations require states to verify provider eligibility upon enrollment or reenrollment, section 44105 would expand this exponentially to require provider eligibility databases to be checked every month, by every state, for every provider. Such a requirement would necessitate increased staffing, resources, and expenditures at a time when efficiency in Medicaid is at a premium. The AMA favors these eligibility checks to be conducted upon provider enrollment and reenrollment, so as to avoid inefficiencies and undue administrative burden which could ultimately threaten patient access to Medicaid services.

In a similar vein, section 44106 adds a requirement to screen providers against the Social Security Administration's Death Master File (DMF). We believe being listed in the DMF could be an important data point to flag further inquiry into the provider's eligibility. However, we are also aware that false positives (names of living individuals) are erroneously added to the DMF at an average rate of 5,500 per month. The AMA recommends that any use of the DMF to determine provider eligibility would use the occurrence of a provider's name in the DMF as a trigger for further inquiry before pursuing any action adverse to that provider's participation in Medicare or Medicaid. Otherwise, should a provider be automatically barred from participation based on a false positive, that provider would suddenly be cut off from access to the program and more importantly, from their patients. Resolving the false positive by confirming the living provider's eligibility status could require an extended amount of time given the scale of these programs and state staffing levels. Such a delay would unnecessarily disrupt patient care, place strain on small provider practices, particularly those with limited administrative capacity, and could ultimately force some physician practices to close, exacerbating the problem of patient access to their provider or to any care under these programs.

Again, while the AMA generally supports program integrity initiatives in Medicaid and CHIP, we would recommend that the Committee include safeguards to ensure that physician practices and other providers are not erroneously barred from participating in these programs. These safeguards could include giving providers notice and an opportunity to appeal before they are adversely affected. Preventing providers who are without fault from participating in Medicaid and CHIP threatens beneficiary access to care and, in some cases, the continued viability of providers.

Another matter that raises concern is the new cost sharing requirements included in section 44142. While the new cost sharing requirements would only apply to Medicaid expansion patients with incomes that are greater than 100 percent of the federal poverty level ($15,650 for a household of one in 2025), even modest cost sharing requirements can deter patients from accessing medical care. There is an extensive body of research showing that copayments can make it harder for low-income people to afford needed medical services and force them to make difficult choices between needed health care and other basic necessities, such as food and rent.[16] This is especially the case for individuals with chronic conditions who may require more frequent medical care and thus be charged more copayments. As physicians, we

[16] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

fear that the proposed cost sharing provisions could pose barriers to Medicaid beneficiaries' ability to access medically necessary services in a timely fashion, including adhering to physician-prescribed therapies, which could lead to delays in treatment, increases in emergency room visits and hospitalizations, and other expensive forms of care.

The AMA appreciates the Committee's ongoing efforts to strengthen the nation's health care system and urges careful consideration of the potential impact of proposed changes on physicians and the patients they serve. We stand ready to work collaboratively with Congress to advance policies that promote access to high-quality, affordable care, ensure the sustainability of physician practices, and protect the integrity of vital safety net programs like Medicare, Medicaid, and CHIP.

Sincerely,

James L. Madara, MD