COLLEGE of AMERICAN PATHOLOGISTS

Statement for the Record

College of American Pathologists

House Energy and Commerce Committee
Subcommittee on Health

Re: Subcommittee on Health hearing titled Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms.

May 18, 2026

The College of American Pathologists (CAP) submits this statement for the record in response to the Committee's hearing on **Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms** to detail policies the CAP believes Congress should adopt to ensure patient access to necessary diagnostic testing. As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide. As physicians specializing in the diagnosis of disease through laboratory methods, pathologists have a long track record of delivering high quality diagnostic services to patients and other physicians.

Patients and their treating physicians rely on the expertise of pathologists. From blood to urinalysis, pathologists and the services they provide, including ensuring laboratory quality in communities across the United States, are at the foundation of our health care system. The work pathologists and their labs do touches everyone in the United States. Therefore, the CAP believes it is vitally important for Congress to address the issues below. **As an initial matter, the CAP believes Congress must act before the end of this year to ensure that the 2.5% conversion factor adjustment Congress passed in 2025 for 2026 continues in 2027, and beyond, until permanent reforms to stabilize the Medicare Payment System are enacted.**

Payment Reform

1. Provide an Inflationary Update to the Medicare Physician Fee Schedule

Over the last 10 years, payments to pathologists have decreased by over 9 percent, while physician practice costs (medical supplies, lab personnel costs, professional liability insurance) have increased by over 24 percent. With inflation, in 2026 alone, pathologists are facing a net 2.4 percent reduction in MPFS revenues as Medicare reimbursement increases 0.3 percent and expenses rise by over 2.7 percent. If not for the temporary relief from the One Big Beautiful Bill Act, the net reduction would have been 4.9 percent as pathologist Medicare reimbursements would have decreased by 2.2 percent. The lack of full annual inflationary updates for pathologists, especially those that operate small businesses, compounds the wide range of shifting economic factors impacting the practice of

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pathology, such as increasing administrative burdens, staff salaries, office rent, and purchasing essential technology when determining their ability to provide care to Medicare patients. The absence of full annual inflationary updates, combined with the MPFS' statutory budget neutrality requirements and ongoing Medicare payment cuts, further compounds the difficulties pathologists face in managing resources to continue caring for patients in their communities. **As such, the CAP supports HR 6160, the Strengthening Medicare for Patients and Providers Act, introduced by Reps. Ruiz (D-CA-25), Bilirakis (R-FL-12), Panetta (D-CA-19), Bera (D-CA-6), Schrier (D-WA-8).** The CAP understands that other bi-partisan proposals are being discussed to provide an inflationary update to the physician fee schedule and the CAP welcomes those efforts and looks forward to working with Congress to provide the maximum inflationary update possible.

2. **Efficiency Adjustment**

On January 1, 2026, the CMS implemented an efficiency adjustment based on their concern that productivity efficiencies are not accounted for in current physician work RVUs for non-time-based services. The efficiency adjustment decreased the work RVUs and the intra-service physician time for non-time-based services by 2.5%. This policy reduced payment for more than 7,000 physician services. The efficiency adjustment policy, applied broadly, overlooks the realities of modern medical practice. It does not reflect factors that increase physician workload, such as rising patient complexity and the evolution of medical technologies. For instance, emerging tools such as AI can generate significant amounts of additional information, requiring added interpretive work and time.

Further, increased patient complexity also requires additional physician review, confirmation of findings, or correlation with other studies for a pathologist to provide a cancer diagnosis. Rather than creating net efficiencies, changes in medical practice may intensify the interpretive and documentation burden placed on physicians. **Therefore, Congress must reverse this flawed policy by passing HR 7520, the Efficiency Adjustment Delay Act, introduced by Reps. Estes (R-KS-04) and Suozzi (D-NY-03).**

3. **Budget Neutrality**

Budget neutrality leads to reductions in reimbursement unrelated to the cost of providing care and is a major barrier to achieving high-quality, high-value health care. Such payment instability puts physicians in the difficult position of determining the economic feasibility of providing care to Medicare beneficiaries. CAP acknowledges that budget neutrality is a politically appealing option to control rising health care costs. However, Congress should think more creatively and expansively about ways to manage health care costs. CAP urges Congress to adopt a solution that leads to stability for health care providers and does not threaten beneficiary access to essential health care services. **To that end, Congress should pass H.R. 8163, introduced by Reps. Murphy, MD (R-NC-3), Suozzi (D-NY-3), Joyce, MD (R-PA-13), Onder, MD (R-MO-3), Schneider (D-IL-10), Panetta (D-CA-19), Miller-Meeks, MD (R-IA-1), Schrier, MD (D-WA-8), and Kelly (D-IL-2).**

MACRA Reform

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The CAP appreciates Congress's recognition of the need for broad improvements to the quality improvement program in traditional Medicare. To that end, the CAP asks that Congress pass legislation to ensure MIPS, or some iteration of it, include metrics and measures that reflect, respect, and value the way physicians practice and their role in the health care ecosystem.

1. **Outcome Measures**

Diagnoses drive treatment decisions. Unfortunately, their value has been understated in the current MIPS paradigm. MIPS currently uses a narrow definition of outcomes. We agree with the focus on real outcomes for any quality program and suggest considering an outcome from the patient's perspective: an outcome is something that matters to a patient and improves his or her health, understanding of their condition, or ability to act on their own health. For example, patients with chronic pain who gain a better understanding of how to manage their pain may not improve qualitative pain scores in the short term, but gaining empowerment is also important for their health.

Similarly, a complete diagnosis that is clearly explained to patients is an outcome, as it also promotes understanding and action on individual health. In fact, diagnosis is a key outcome: effective management of a disease follows a correct diagnosis as do any subsequent outcomes related to treatment decisions based on the diagnosis. **As such, the CAP asks that Congress amend the MIPS statute. Specifically, section 1848(q) of the Social Security Act (42 USC 1395w-4(q)) as follows:**

(C) Additional provisions

> **(i)** Emphasizing outcome measures under the quality performance category. -
> In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures, including intermediate outcomes and other alternative types of outcomes relevant to non-patient facing clinicians, such as diagnostic accuracy, turnaround time, and report completeness.

Currently, the CMS considers a test result a process measure not an outcome measure. CAP has consistently made the case to the CMS that a diagnosis is the outcome of the process pathologists employ to ensure patients receive the care and treatment they need. The CMS continues to reject our position. The problem is that the CMS is eliminating process measures. The CMS is increasingly focused on patient specific outcomes measures, i.e. did the patient stop smoking, is the patient's A1C below "x" level. While vitally important, these are outcomes pathologists do not control.

2. **Topped Out Measures**

Pathology measures should ensure high, continuous compliance, address gaps in performance, and reflect clinical guidelines. For example, a quality measure on Barrett's Esophagus[1], which could lead

[1] Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dysplasia (ACG, 2022; AGA, 2011). There is a rapidly rising incidence

to esophageal cancer, that requires reporting on "Esophageal Biopsy Reports" should not be removed because pathologists are successful. It's critically important that timely and accurate diagnosis and test reports are continuously performed and delivered at a high level.

As updates to clinical guidelines are made, updated measures should reflect those changes. Measures that do not reflect those changes should be retired. As new therapies, gene variants, and technologies are developed, measures should evolve to respond to those developments. For example, a guideline update was needed to improve the analytic validity of HER2 testing (protein typically found in breast cancer cells) and the clinical utility of HER2 as a predictive biomarker for potential responsiveness to therapies targeting the HER2 protein. **As such, the CAP asks that Congress amend the MIPS statute. Specifically, Sec. 1848(q) of the Social Security Act (42 USC 1395w-4(q)) as follows:**

(D) Annual list of quality measures available for MIPS assessment

> **(aa)** removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that ~~are topped out~~ no longer meet clinical guidelines);

Additionally, to ensure clinical guidelines are considered when developing performance standards, **the CAP recommends amending Sec. 1848(q)(3)(B) as follows:**

(3)Performance standards.—

> **(A) Establishment.—** Under the MIPS, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.
>
> **(B) Considerations in establishing standards.—** In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall consider the following:
>
> (i) Historical performance standards.
> (ii) Improvement.
> (iii) The opportunity for continued improvement.
> (iv) Clinical Guidelines

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of adenocarcinoma (cancer) of the esophagus in the United States. A diagnosis of Barrett's esophagus increases a patient's risk for esophageal adenocarcinoma by 30 to 125 times that of people without Barrett's esophagus (although this risk is still small 0.4% to 0.5% per year) (Conteduca et al 2012, Intl J Onc). Esophageal adenocarcinoma is often not curable, partly because the disease is frequently discovered at a late stage and because treatments are not effective. A diagnosis of Barrett's esophagus could allow for appropriate screening of at-risk patients as recommended by the American College of Gastroenterology.

Expand Application of Non-Patient Facing Language in MIPS to Other Programs

CAP appreciates the inclusion of non-patient facing language in the MIPS statute. However, that language only applies to the MIPS program. It is equally important that the non-patient language in MIPS be strengthened and expanded to apply to all current and future quality metrics, categories, and value-based programs, including APMs and ACOs. Because of the non-patient-facing language in MIPS, pathologists are eligible for two MIPS categories: Improvement Activities (IA) and Quality. Pathologists are exempt from the Promoting Interoperability (PI) and Cost categories. However, the remaining categories do not adequately reflect the way pathologists practice.

Improvement Activities

Non-patient-facing clinicians report fewer Improvement Activities because many of the IA measures developed by the CMS are patient-facing. Additionally, the CMS is reducing the measures in that category, leaving even fewer measures for pathologists to choose from. Unfortunately, those patient-facing measures are included in the Pathology MVP developed by the CMS for pathologists. For example,

- The Pathology MVP includes the following patient-facing IAs:
  - Engagement of Patients, Family, and Caregivers in Developing a Plan of Care.
  - Promote Use of Patient-Reported Outcome Tools.
  - Regularly Assess Patient Experience of Care and Follow Up on Findings.
  - Electronic submission of Patient Centered Medical Home accreditation.
  - Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data.

To that end, the CAP asks that Congress amend the non-patient facing language in MIPS, **Sec. 1848(q) of the Social Security Act (42 USC 1395w-4(q))**. One suggested modification to the language could be:

Amended Non-Patient Facing Language

‘‘**(iv) ~~Application of measures and activities to non-patient professions~~ Application of quality and value-based programs to non-patient facing professionals**. **—** In carrying out this paragraph with respect to current and future quality and value-based programs, including, but not limited to the Merit-based Incentive Payment System (MIPS), the MIPS Value Pathways (MVPs), and Alternative Payment Models (APMs), the Secretary, in developing performance categories, measures, and activities—

‘‘(I) ~~shall give consideration to the~~ Must account for the circumstances of professional types (or subcategories of those types determined by practice characteristics) ~~who typically furnish services that do not involve face-to-face interaction with a patient~~ who typically furnish services that do not typically involve face-to-face interaction with a patient or when face-to-face interaction occurs, it is at the direction of the ordering clinician; and

‘‘(II) ~~may~~ Must ~~to the extent feasible and appropriate,~~ take into account such circumstances with respect to ~~and apply under this subsection with respect to MIPS~~ eligible professionals of such

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professional types or subcategories, alternative measures, performance categories, and activities that fulfill the goals of the applicable ~~performance category.~~ current and future quality and value-based programs. In carrying out ~~the previous sentence,~~ this section, the Secretary ~~shall~~ must consult with professionals of such professional types or subcategories.

Make Local Coverage Determinations (LCD) Process More Transparent

While reforms to the LCD process are not part of MACRA, they are crucially important because access to critical diagnostics and services save lives, reduce costs, and improve patient care. To that end, CAP urges Congress to pass the **Timely Access to Coverage Decisions Act (H.R. 8500), introduced by Reps. Dunn, MD (R-FL-2), Barragán (D-CA-44), and Tenney (R-NY-24).** H.R. 8500 will reform the Medicare local coverage determination (LCD) process to ensure that coverage decisions are made by qualified health experts through a transparent process that is based on sound medical evidence.

LCDs are developed by Medicare Administrative Contractors (MACs) on whether, and under what circumstances, to cover a particular item or service on a contractor-wide basis. As a result of contractor reforms that have taken place over the years, MACs are responsible for much larger jurisdictions, often with fewer opportunities for stakeholders to interact with the key officials. Despite changes made to improve program integrity, the LCD process continues to lack transparency and sufficient stakeholder involvement to ensure that decisions are made in the best interests of patients.

To address the ongoing issues with the LCD development process, H.R. 8500 would:

1. **Create a timeframe for reviewing LCD requests, including reconsideration**. MACs must review formal LCD requests (including reconsideration requests) and determine whether they are complete within 60 days of the request. After determining that an LCD request is complete and no later than one year before finalizing an LCD after that determination, the MACs must publish a draft of the LCD, hold an open meeting, and seek input from qualified experts, including physicians, device manufacturers and patients. Further, should stakeholders have concerns with an LCD promulgated by a MAC, they can request that the MAC reconsider the LCD. After that request is made and deemed a complete request, the MAC must respond to the request within one year.

2. **Additional Oversight from CMS.** To safeguard against errors or misinterpretation of evidence used to support a coverage policy, and to ensure adherence to coverage regulations, an interested party may request a review by CMS of the MAC's reconsideration decision to ensure that evidence was inaccurately applied, the LCD doesn't include language outside its scope, or failed to describe the clinical conditions it used to determine whether an item or service was reasonable and necessary.

3. **Make the LCD process more transparent and include appropriate stakeholder input.** MACs must hold one or more open public meetings once an LCD has been proposed, provide the agenda for the meeting 14 days in advance, secure the advice of an expert

panel that includes patient, physician, and industry stakeholders, and post the record of each meeting 14 days after the meetings are complete. Before finalizing an LCD, in addition to publishing a response to public comments, the MAC must provide a response to the relevant issues raised at the open public meeting and the meeting of experts. Finally, the MAC must post the full text of all public comments and any evidence the MAC used to make its decision that was not mentioned in the proposed LCD.

4. **Logical Outgrowth of Draft LCD**. A final LCD must be a logical outgrowth of the draft LCD. Any updates to an LCD that are not a logical outgrowth of the draft must be reissued as a draft LCD before finalization.

Site of service

Finally, CAP urges Congress to resist adopting site neutral policies to pay for reforms. Site neutral payment proposals fail to take into consideration the technical costs associated with specific procedures and services and fail to recognize the distinct site-specific practice costs of physician services, which are required by law to be based on the resources required to perform the service. CMS has previously stated that comparisons between the physician fee schedule (PFS) and out-patient prospective payment system (OPPS) payments for services are inappropriate because of the different nature of the cost inputs and has explicitly refused to impose one payment system or the other in other rulemakings. OPPS data is hospital data and does not reflect the actual resource costs incurred by physicians in their offices or laboratories. The methodology is not designed to allow for comparisons to services outside the OPPS. Current law requires physician services to be resource-based, and Ambulatory Payment Classifications (APCs) are not resource-based. **Implementing site neutrality policies would result in major disruption in the health care system as much of the payment shift would be away from hospital-based physicians and into office-based physicians, likely causing a significant number of hospitals closing their doors.**

The CAP appreciates the opportunity to submit feedback. If you have questions, please contact Darren Fenwick at dfenwic@cap.org.

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