Data Brief and Policy Recommendations on Medicare Payments to Physicians

The American College of Allergy, Asthma and Immunology (ACAAI) appreciates the Committee's interest in addressing challenges related to the Medicare Physician Fee Schedule (PFS) and the Medicare Access and CHIP Reauthorization Act (MACRA).

The American College of Allergy, Asthma and Immunology (ACAAI) promotes excellence in the practice of allergy and immunology. With more than 6,500 allergists and other health care professionals as members, its Advocacy Council is the leader in advocating issues that affect our members, their practices, and their patients.

Allergists are directly impacted by inadequate reimbursements, administrative burdens, and unfunded regulatory mandates.

Physicians spend years training to provide the highest quality patient care. They should spend their time and resources doing what they trained for: caring for patients. Instead, they must dedicate increasing amounts of their time and resources to complying with administrative requirements from both commercial and government payers while also receiving payment rates that often do not reflect the actual cost of care.

While the current environment is a major improvement over the Sustainable Growth Rate (SGR), many challenges remain. Federal agencies such as the Centers for Medicare and Medicaid Services (CMS) can do more to help alleviate these burdens, Congress has authority over most of these issues.

ACAAI's Advocacy Council has created this background memo to provide data that highlights the issues facing providers as well as policy solutions for Congress to consider.

Again, we appreciate the Committee's interest in these issues. Please do not hesitate to contact Matt Reiter (reiterm@capitolassociates.com) if you wish to discuss these recommendations in more detail.

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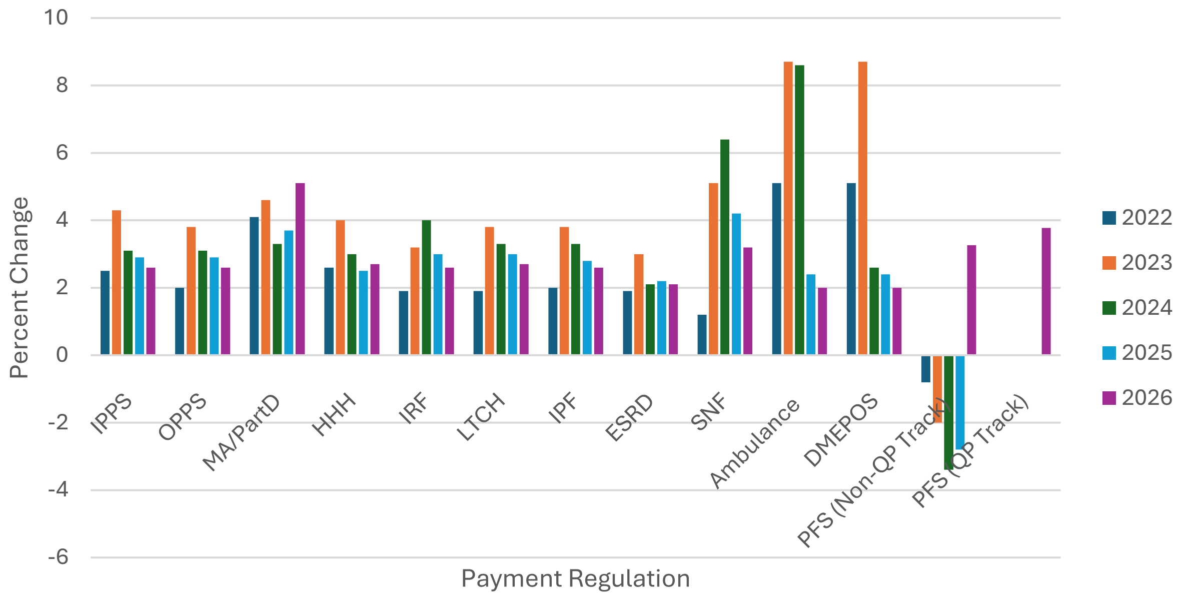
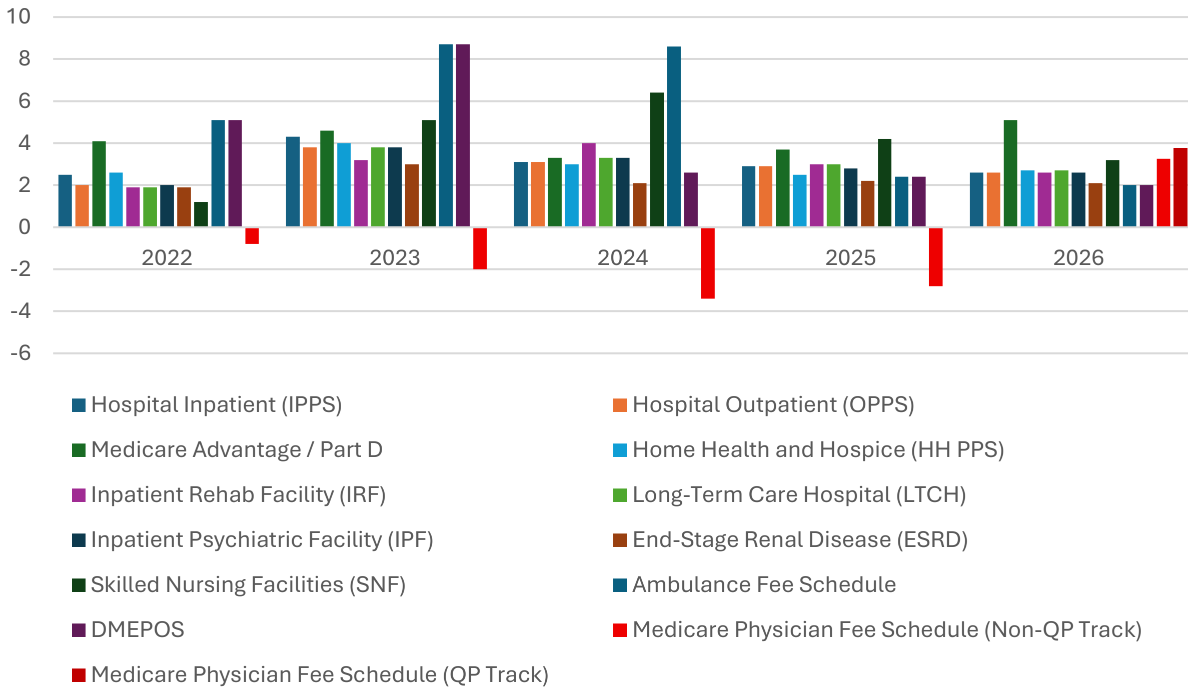
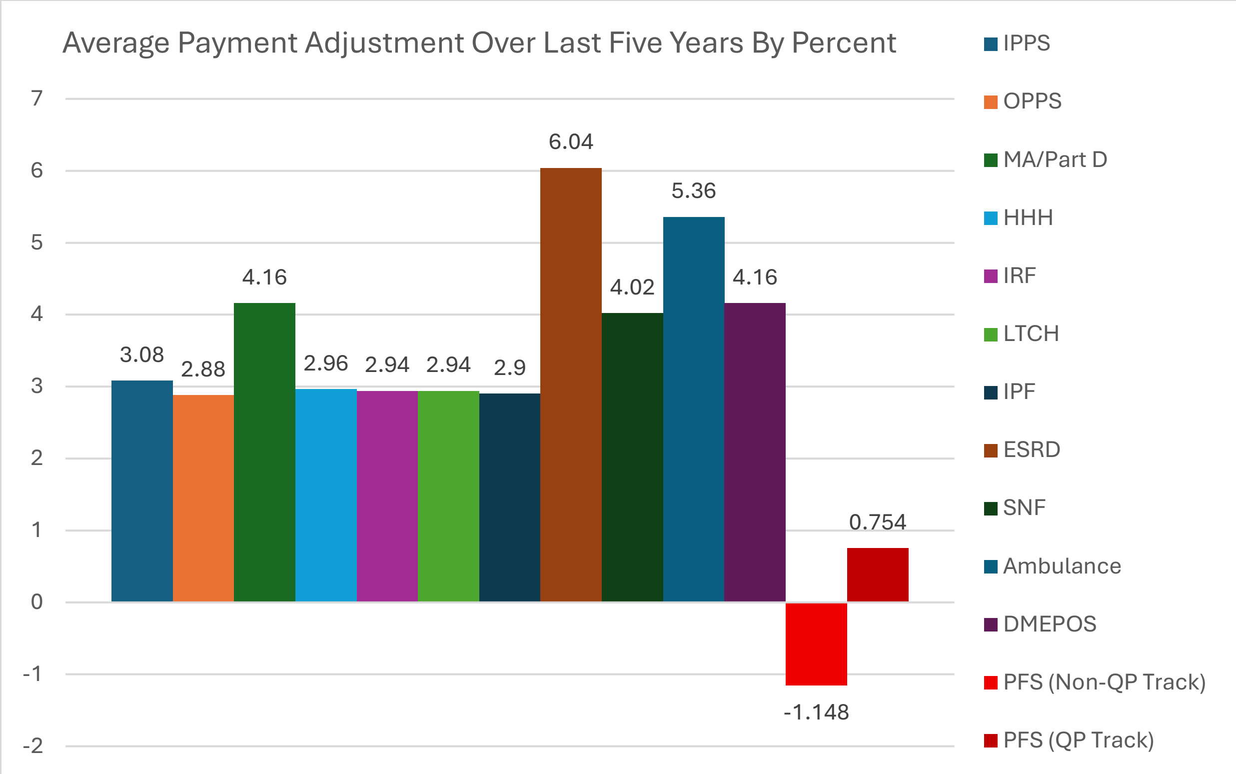
Congress should consider targeted reforms to stabilize physician reimbursement and reduce administrative burdens across the healthcare system.

I. Over the last five years, the Medicare Physician Fee Schedule is the only Medicare payment regulation that provides a payment decrease.

- The Medicare Physician Fee Schedule is the only Medicare payment regulation that has seen a net decrease over any of the last five years.
  - This is because the PFS is the only Medicare payment regulation with a statutory budget neutrality requirement. Any changes within the PFS that exceed $20 million in new spending must be offset by cuts elsewhere in the PFS or through an adjustment to the PFS Conversion Factor. Only Congress has the authority to reform the budget neutrality requirement.
- No other payment regulation had a net cut for any of the last five years. Every other Medicare payment regulation only saw payment increases over this time.
  - The only exception is the Clinical Lab Fee Schedule, which was neutral over the last five years.
- The CY 2026 PFS adjustment offsets a cut of the same amount from CY 2025, thus canceling out the 2026 increase. Putting this one-time adjustment aside, the PFS saw its first positive increase in 2026 of 0.25% or 0.75% depending on the clinician's status as a "Qualifying Participant (QP)" in an Advanced APM.
- Commercial health insurers often base their payment rates on the Medicare rate. For example, a commercial health insurer might offer 110% of Medicare as its payment rate for an item or service. Inadequate PFS adjustments therefore have a compounding effect across the entire payer landscape.


Medicare Payment Regulation Annual Payment Updates 2022-2026
Percent Change
Payment Regulation
10
8
6
4
2
0
-2
-4
-6
IPPS
OPPS
MA/PartD
HHH
IRF
LTCH
IPF
ESRD
SNF
Ambulance
DMEPOS
PFS (Non-QP Track)
PFS (QP Track)
2022
2023
2024
2025
2026


Medicare Payment Regulation Annual Payment Updates 2022-2026
10
8
6
4
2
0
-2
-4
-6
2022
2023
2024
2025
2026
Hospital Inpatient (IPPS)
Hospital Outpatient (OPPS)
Medicare Advantage / Part D
Home Health and Hospice (HH PPS)
Inpatient Rehab Facility (IRF)
Long-Term Care Hospital (LTCH)
Inpatient Psychiatric Facility (IPF)
End-Stage Renal Disease (ESRD)
Skilled Nursing Facilities (SNF)
Ambulance Fee Schedule
DMEPOS
Medicare Physician Fee Schedule (Non-QP Track)
Medicare Physician Fee Schedule (QP Track)



Average Payment Adjustment Over Last Five Years by Percent Data Table	
Payment Regulation	**Average Annual Update Over Last Five Years (%)**
Hospital Inpatient (IPPS)	3.08%
Hospital Outpatient (OPPS)	2.88%
Medicare Advantage / Part D	4.16%
Home Health & Hospice	2.96%
Inpatient Rehab Facility	2.94%
Long-Term Care Hospital	2.94%
Inpatient Psychiatric Facility	2.90%
End-Stage Renal Disease	2.26%
Skilled Nursing Facility	4.02%
Ambulance Fee Schedule	5.36%
DMEPOS	4.16%
Physician Fee Schedule (Non-QP)	**-1.15%**

i. Medicare reimbursements for allergy shots are inaccurate and inadequate.

What is Allergy Immunotherapy?

Allergy immunotherapy, commonly known as allergy shots, is a treatment used by allergists to help patients manage allergies. This therapy works by gradually exposing the immune system to small amounts of allergens—the substances causing allergic reactions. Over time, the doses increase, sometimes up to 100,000 times stronger than the initial dose. Patients receiving allergy shots demonstrate a significant healthcare system cost savings when compared to patients treated with medications alone.[1]

This process begins with a "buildup phase" which starts with a low allergen dose that gradually increases over time to help the immune system become less sensitive to allergens. Once the maximum dose is reached, patients receive "maintenance doses" to sustain the effect and achieve long-term relief.

What is CPT Code 95165?

CPT (Current Procedural Terminology) codes are standardized codes used by doctors to bill insurance companies for medical procedures. CPT code 95165 covers the professional services involved in preparing allergy shot antigens (the allergen mixtures used in the shots) for single or multiple allergens.

Allergists create customized mixtures of allergen extracts into patient-specific vials that will be used for multiple administrations of allergy shots. Vials usually last for several months, depending on the patient's treatment plan and if they are in the buildup or maintenance phase.

A patient's vial typically includes multiple allergen extracts (e.g., grass, trees, dogs, cats, etc.). The amount of doses per vial varies based on the individual patient's treatment plan. New vials are created after one is used up. This billing code accounts for both buildup and maintenance vials and allows flexibility based on a patient's unique needs, such as their sensitivity to allergens or response to treatment.

Under CPT guidelines:

- Doctors bill based on the number of "doses" expected to be given from a vial, as determined by the patient's prescribed dosage and treatment schedule.

[1] https://pubmed.ncbi.nlm.nih.gov/23375206/

- A “dose” refers to the total allergy extracts administered to the patient, not a specific volume of liquid.
- The code’s definition of dose reflects the individualized nature of allergy shots, accommodating variations in patient treatment plans.
- Related allergy shot CPT codes 95115 and 95117 define dose as “a single injection from a multidose vial.”

How Medicare Defines 95165 Differently

Medicare, however, does not use CPT’s dose definition for CPT 95165, which creates confusion and problems:

- Medicare defines a “dose” (or “aliquot”) as exactly 1 cubic centimeter (cc) of liquid, regardless of the actual amount of allergy extract given to the patient.
- It limits billing to a maximum of 10 “aliquots” per vial, even if more is used.
- This definition ignores the individualized dosing required for effective treatment, as patients vary in their allergic sensitivity and treatment needs.

Medicare’s rigid approach leads to:

- **Confusion**: The 1 cc “dose” does not match the actual dose given to patients, complicating billing.
- **Billing Errors**: Doctors, who are used to relying on CPT code definitions, may struggle to align their billing with Medicare’s definition, leading to inaccuracies.
- **Treatment Risks**: Misalignment between billed and administered doses can increase the risk of errors in giving shots.
- **Lower Reimbursements**: Medicare’s inaccurate definition of “dose” fails to adequately reimburse allergy practices for preparing allergy shots. The CY 2026 Medicare Physician Fee Schedule final rule increases Medicare payments for CPT Code 95165 by 45%, which is extremely helpful. However, this does not negate the need for a more accurate definition of “dose.”

Why This Matters

Many private insurance companies follow Medicare’s lead when setting their coverage policies. We have seen a recent trend of commercial health plans adopting Medicare’s 1 cc

dose definition for 95165.[2] To make matters worse, these insurers use the CPT's payment value (designed for the flexible, patient-specific definition), which results in lower payments to doctors for their services. This under-valuation can limit access to allergy immunotherapy and affect the quality of care.

Allergy immunotherapy is at the core of every allergy practice. Commercial payers are beginning to adopt Medicare's coverage policy which exacerbates the impact of this flawed coverage policy. Many allergy practices are having difficulty breaking even preparing immunotherapy vials when payers do not align with CPT's definition of dose and reimbursement value.

The Solution

To ensure fair and accurate billing, Medicare should align its definition of CPT 95165 with other allergy shot codes by replacing its definition of "dose" for CPT Code 95165 with the definition used by CPT codes 95115 and 95117, which define dose as "a single injection from a multidose vial."

This change would:

- Reflect the individualized nature of allergy shots.
- Reduce confusion and billing errors.
- Ensure accurate payment for allergists, supporting better patient care.
- Set an example for how commercial insurers should cover this code.

[2] https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Maximum-Frequency-Per-Day-Policy.pdf

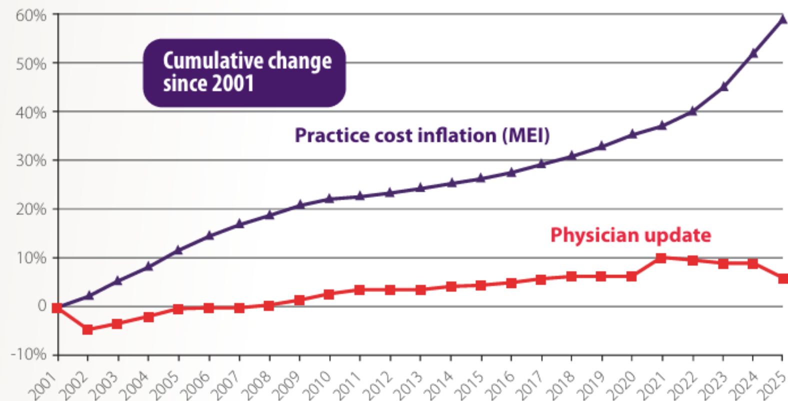
II. Inflation has outpaced updates to the Physician Fee Schedule Conversion Factor by 33% since 2001.

- Healthcare inflation, measured by the Medicare Economic Index (MEI), outpaced updates to the Medicare Physician Fee Schedule by 33%, which means that Medicare payment updates to clinicians are not keeping up with rising costs.
- The Conversion Factor (CF) serves as a proxy for overall physician payment adjustments. Adjustments for each specialty can vary from the CF.
- The budget neutral requirement creates a system of winners and losers within the PFS.
- Legislation such as H.R. 2489 (118th Congress) would provide annual inflationary updates equal to MEI, separate from budget neutrality adjustments.

Medicare physician payment continues to fall further behind practice cost inflation.

Medicare updates compared to inflation in practice costs (2001–2025)

Adjusted for inflation in practice costs, Medicare physician payment **declined 33%** from 2001 to 2025.

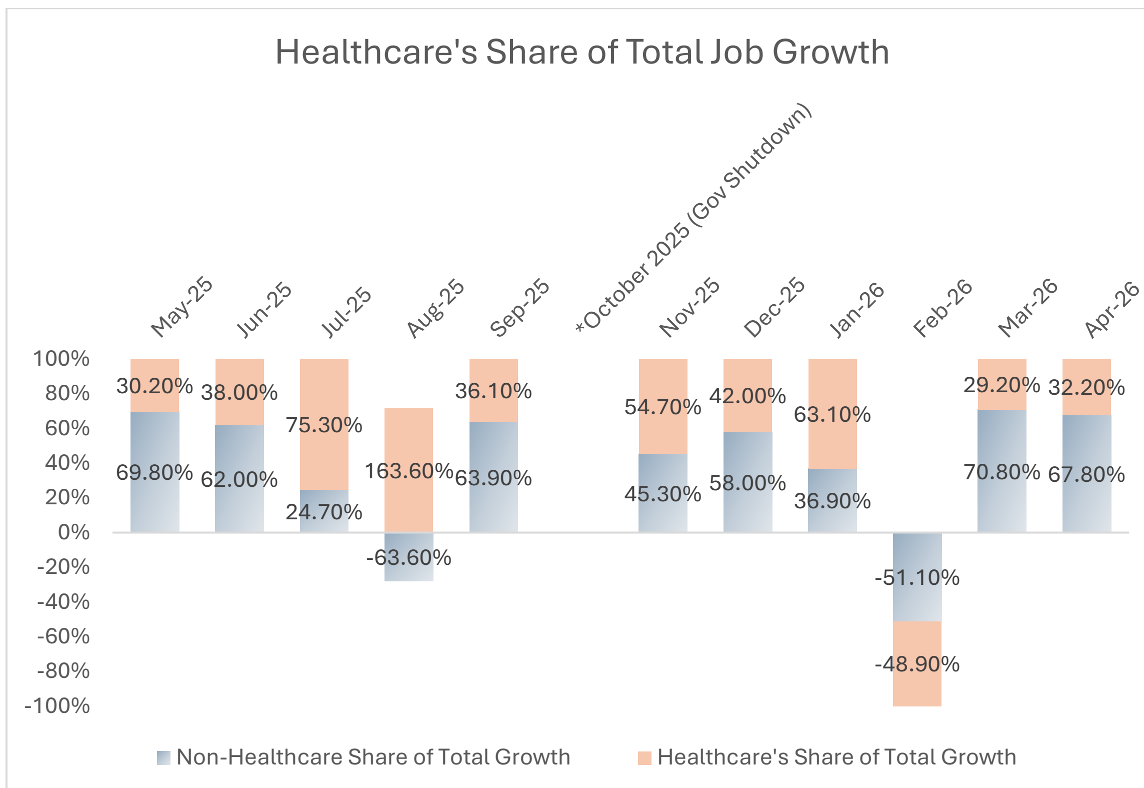


Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office.

Updated Jan. 2025

III. Healthcare jobs are driving U.S. job growth.

- Recent Bureau of Labor Statistics (BLS) reports show that healthcare employment continues to account for a disproportionate share of total U.S. job growth. Policymakers should consider the broader labor market implications of reimbursement reductions to healthcare providers, particularly physician practices and outpatient care settings.
- Healthcare jobs are measured by BLS NAICS Code 62 to define "Health Care and Social Assistance." This sector is further broken down into four subsectors, which include: (1) Ambulatory Health Care Services: NAICS 621, (2) Hospitals: NAICS 622, (3) Nursing and Residential Care Facilities: NAICS 623, and (4) Social Assistance: NAICS 624. "Healthcare jobs" typically refers to only the first three of these subcodes. Physicians' Offices are reported under NAICS subcode 6211. According to a BLS report from 2023, there were 2,842,350 individuals employed in Physicians' Offices.



Data from National Bureau of Labor Statistics

IV. MIPS does not provide sustainable payment increases to clinicians. Similarly, the cost of compliance could offset any potential positive payment adjustments.

- The Merit-based Incentive Payment System (MIPS) is not functioning as Congress intended. Despite offering the potential of a +/- 9% adjustment depending on a clinician's performance score, MIPS clinicians are not receiving any meaningful positive increase.
- **For the CY 2026 payment year, the maximum positive payment adjustment a clinician could earn for a 100% performance score was 1.05%.**
    - **As shown above, this amount is offset by net payment decreases clinicians received in the PFS over recent years.**
- MIPS payment adjustments are budget neutral. The negative payment adjustments fund the positive payment adjustments. MIPS payment adjustments are on a sliding scale to ensure budget neutrality. While it is a good thing that most clinicians avoid a negative payment adjustment, this exploits a structural flaw with budget neutrality by severely limiting the amount of money available for positive payment adjustments.
- The American Medical Association (AMA) cites research that shows MIPS compliance costs $12,800 per physician annually and requires more than 53 hours per year on quality assurance tasks.[3]
- Most clinicians report MIPS data through their electronic health record (EHR). EHRs and other vendors provide MIPS reporting services to clinicians to automatically calculate the best way to report MIPS data based on the provider's EHR data.
- MIPS does not effectively measure or hold clinicians accountable for quality. Most MIPS quality measures are "process" measures that are not linked to outcomes. Many specialties do not have enough applicable quality measures to earn full credit for the Quality reporting category.
- There are still many flaws with how certain reporting categories are structured. For example, the Cost category measures non-physician practitioners (NPP) using primary care cost measures even if those clinicians support specialists and are not providing primary care services themselves. This results in a negative score for these clinicians which impacts the score of the entire group.

[3] https://www.ama-assn.org/health-care-advocacy/advocacy-update/may-8-2026-national-advocacy-update

V. Policy Solutions

1. **Congress should pass legislation that automatically updates the PFS Conversion Factor by MEI. This adjustment would not be subject to the PFS budget neutrality requirements.**
   While this policy would certainly increase Medicare spending compared to current levels, physicians are the only provider-type that does not receive annual payment increase due to budget neutrality restrictions. As shown above, every other annual Medicare payment regulation provides annual increase.

   Additionally, providing care in the physician office setting is often more cost-effective than other settings and allows clinicians to manage patient care which provides additional long-term health benefits to patients and savings for Medicare. It is in Congress's interest to incentivize care in the physician office setting.

2. **Pass legislation such as the Provider Reimbursement Stability Act which would give Medicare more flexibility when making budget neutrality adjustments**.
   The bill would increase the threshold for automatic budget neutrality adjustments from $20 million to $53 million. It also caps downward adjustments to clinicians at 2.5%.

3. **Simplify the MIPS program.**
   MIPS is too administratively complex and offers too small of a payment increase to effectively incentivize value-based care. Congress should replace MIPS with a simpler program that is easier for clinicians to understand, participate in, and report under. Additionally, it should limit payment penalties while adequately rewarding clinicians who succeed in the program.

4. **Reauthorize and fund the MIPS Exceptional Performance Bonus Pool.**
   When Congress created MIPS, it included a separate pool of money to fund bonuses for exceptional performance bonuses. This bonus pool expired after five years. Congress should reauthorize it to help provide meaningful payment increases to clinicians under MIPS.

5. **Eliminate administrative burdens throughout the healthcare system.**
   Medicare is only one part of a large ecosystem of healthcare payers. While Medicare is often the leader on important value-based care initiatives, commercial payers do not always align with Medicare.

   Additionally, administrative burdens from commercial and government payers continue to make it harder for independent medical practices to provide care to patients. Only 18% of physicians practice in a physician-owned setting.[4] Commercial health plans are among the top drivers of administrative challenges. Prior authorizations, claim denials and supplemental documentation requests force providers to appeal and fight for every dollar.[5] In many cases, providers lose money if the cost to appeal exceeds the amount that was denied.

   Additionally, some health insurers use third-party payment vendors to facilitate electronic payments to providers on their behalf. These vendors charge transaction fees that further subtract from the total payment amount to clinicians.[6]

   This hearing should be the beginning of a larger conversation about how Congress can improve Medicare reimbursements to physicians and support independent medical practices.

[4] https://radiologybusiness.com/topics/healthcare-management/mergers-and-acquisitions/82-radiologists-and-other-physicians-now-employed-corporate-entities

[5] https://democrats-edworkforce.house.gov/download/denied-how-the-health-care-industry-stacks-the-deck-against-working-families

[6] https://murphy.house.gov/media/press-releases/murphy-introduces-bipartisan-legislation-eliminate-costly-health-care-fees