



Statement for the Record

Energy and Commerce Health Subcommittee

**Hearing on “Examining the Medicare Physician Fee Schedule, MACRA, and
Opportunities for Payment Reforms”**

May 20, 2026

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Chairs Guthrie and Griffith and Ranking Members Pallone and DeGette, on behalf of Families USA, thank you for holding this important and timely hearing.

Every family across our nation should have access to the health care they need at a price they can afford. Yet rather than being designed to deliver the highest-quality care for the lowest possible cost, the U.S. health care system is currently designed to rake in the highest possible profits for big health care corporations with little regard to health outcomes – all while millions of Americans struggle to afford their care.

Policymakers must take urgent action to realign the economic incentives of health care payment and delivery so that the health care sector only economically thrives when it is providing affordable, high-quality health care to our nation's families. The Energy and Commerce Committee should advance reforms that both immediately address the most egregious flaws in the Medicare physician payment system and build a strong foundation for longer term pathways to true accountability for the cost and quality of care and the health of families and patients.

Fee-For-Service Payment Driving Low-Quality, High-Cost Care

One of the biggest drivers of our nation's health care affordability and quality crisis is the way the U.S. pays for health care – a payment system largely based on fee-for-service (FFS) economics that drives the fragmented and poorly coordinated health care that the majority of our nation's families now experience. Fee-for-service payments incentivize health care providers to make money by performing higher volumes of high-profit or high-margin procedures, rather than by allowing providers to generate a profit or margin based on keeping people healthy and reducing disparities.¹ Ultimately, FFS payment not only drives up health care costs but has no relationship health care quality or improved health outcomes.² The effects of these broken FFS payment incentives are amplified through physician payment across the health care system and serve as the basis for Medicare payment – one of the largest and most important payers in U.S. health care – through the Medicare Physician Fee Schedule (MPFS). FFS payment incentives predominate in all forms of health insurance, including Medicare Advantage, Medicaid managed care, private insurance, traditional Medicare and Medicaid, and the majority of existing value-based payment models. Medicare payment policy, including the Medicare Physician Fee Schedule, is perhaps one of the most critical levers for shifting the country away from FFS economics towards a value-based payment system that drives improvements in health while containing health care costs.

Moreover, as Medicare spending and beneficiary out-of-pocket costs climb, the disparities embedded into the Medicare Physician Fee Schedule are amplified across our system. Flaws in how payments are established and disparities that value specialty care over primary care and behavioral health services continue to drive critical provider shortages and restrict access to the health care services many patients need.³

The shortcomings of fee-for-service payment are well-documented. Yet, despite more than 15 years of efforts to move away from FFS payment, most notably through enactment of Medicare Access and CHIP Reauthorization Act (MACRA) reforms and the implementation of dozens of new payment and delivery models, the majority of health care reimbursement still flows through FFS

payments.⁴ Now is the time for Congress to reform the way we pay for health care and to accelerate meaningful payment reform efforts that hold providers accountable for the total cost of health care and improving population health outcomes. These policy reforms must focus both on making critical improvements to the MPFS and strengthening the pathways for more providers to shift into full risk, population-based payment models. Ultimately, lawmakers must work towards establishing population-based payments as the core reimbursement model for health care services through Medicare.

Physician Payment Rate Setting in the Medicare Physician Fee Schedule

Addressing the flaws of the MPFS is critical to both improving current physician reimbursement and advancing the move towards a value-based health care system. Existing flaws in the MPFS undermine access to high-value health care and contribute to overspending on select specialty care.⁵ The most significant flaws include:

1. **Conflicts of interest in the payment update process:** Updates to MPFS service valuation have historically been informed by recommendations from the American Medical Association's Relative Value Update (RVU) Committee (RUC), which relies on survey data from physician specialty associations. The nonpartisan experts at the Government Accountability Office and the Medicare Payment Advisory Commission have repeatedly sounded the alarm that the specialists sitting on the RUC have a financial interest to inflate their estimates, leading to biased estimates of RVUs and distorted fees.^{6, 7} Evidence shows that fees for procedures, imaging and tests are priced too high, and fees for time spent with patients are priced too low, creating a massive distortion in the MPFS. The result is that specialty care is often overvalued at the expense of primary care leading to higher reimbursement for specialty care while further deepening the historic under payment of primary care.⁸ Ultimately, the use of the RUC in creating price determinations results in payments that are in the best interests of specialty providers rather than what is in the best interest of consumers.
2. **Distortions in payment across specialties:** Evidence shows that the periodic updates informed by the RUC and used by CMS to establish payments for services have resulted in prices that do not accurately reflect the resources needed to deliver such services, causing some services to be overvalued and priced higher, and others to be undervalued and priced lower.⁹ Specifically for primary care and behavioral health care providers, the time-intensity required to meet patients' needs and the critical thinking and judgement required to manage the health and wellbeing of an increasingly medically complex and aging population are not well represented in the payments established in the MPFS. Wide disparities in compensation persist in the fee schedule,¹⁰ contributing to a growing primary care, geriatric medicine, and behavioral health care provider shortage.¹¹

In recognition of the need to correct the significant distortions in the MPFS, the Calendar Year 2026 (CY26) MPFS final rule took important steps to address the flaws in how Medicare establishes payment rates that have driven overpayments for hospital and specialty care at the expense of primary care and independent practices. These reforms included reducing reliance on the AMA

survey data and updating the physician payment rate-setting methodology to reflect changes in the health care system and gains in efficiency in the delivery of many professional services. These changes will push more dollars into primary care practices that deliver higher-value, lower-cost care to millions of Americans and work to address a key incentive of health care consolidation. **It is critical Congress supports these efforts and opposes legislation like the Efficiency Adjustment Delay Act (H.R.7520), which seeks to undermine the progress made in final CY26 MPFS.**

Shortcomings of MACRA and the Quality Payment Program

Concerns from policymakers and advocates around the role that fee-for-service economics play in driving up health care spending with little accountability for the quality or efficiency of care delivery are not new. The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the deeply flawed Medicare Sustainable Growth Rate (SGR) and created new financial incentives that aimed to shift physician payment away from FFS and towards value-based care through the Quality Payment Program (QPP).

However, nearly a decade after implementation, there are significant concerns about whether the QPP — and the Merit-Based Incentive Payment System (MIPS) in particular — is meeting the intended goal to drive toward high-value health care and into advanced alternative payment models (AAPMs). A major challenge of MIPS is that providers can game the system and self-select which performance measures they're evaluated on, allowing them to report favorably without meaningfully changing their behavior.¹² There is also robust evidence that pay-for-performance programs have little to no success in shifting financial incentives or consistently improving care quality.¹³ Ultimately, the MIPS payment adjustments continue to be rooted in FFS economics, meaning that under the MIPS program, the financial incentives still reward providers for higher care volume rather than higher care quality and improved health. Overall, providers have little incentive to move from MIPS into AAPMs where they are truly accountable for the cost and quality of care they provide. As a result, MIPS has failed as an on ramp to these models, evidenced by the fact that over 50% of traditional Medicare payments continue to flow through traditional fee-for-service payments.¹⁴

The Promise of True Payment Reform

The ability of payment reform to fulfill its promise hinges on inverting the economics of the health sector's business model to enable the sector to generate revenue by keeping people healthy and ensuring health care is affordable, rather than by billing for unnecessary visits and procedures and engaging in anti-competitive behavior and price gouging.¹⁵ The key ingredient to successful payment reform is making it economically advantageous for health care providers to address whole-person health needs. In other words, there must be a viable business model for providers to make the switch to non-FFS payment models, such as population-based payments, which hold providers accountable for health outcomes and the total cost of patient care.

Population-based payment models are based on paying one health care provider — typically a primary care organization or a health system — a single monthly payment, out of which the organization then pays for some or most health care costs for a whole population. Such payment arrangements are coupled with strong quality and outcome metrics to ensure that as providers'

economics change, patients' health thrives. In this way, providers are "at risk" for care that is wasteful and does not improve or protect patients' health but make money when they are efficient and improve or protect patients' health. This model, therefore, is structured to incentivize providers to deliver well-coordinated, high-quality, person-centered care. And the payments can be used to cover a wide range of services, including preventive health, care coordination, wellness services and services that address the social determinants of health, as well as standard medical procedures and services.¹⁶

Recommendations for Congress

Reforming and strengthening the way physicians are paid is foundational to moving our health care system to one that provides the high quality, affordable health care and the improved health that our nation's families deserve. We urge the Energy and Commerce Committee to focus on policy solutions that address the underlying distortions in the Medicare Physician Fee Schedule while continuing to advance reforms that transform our health care system to one in which providers are held accountable for health outcomes and the total cost of care through population-based payments.

We encourage you to work with colleagues in the House and Senate to:

- **Create an independent technical advisory committee** tasked with collecting, developing, and assessing empirical data to inform the valuation of health care services in the MPFS to serve as an alternative to the Relative Value Update Committee.
- **Direct CMS to correct misvalued services** in the fee schedule to address distortions that have resulted in the overpayment of select specialty services and undervaluing of the services critical to meeting consumer needs, such as primary care and behavioral health.
- **Reform MACRA to better prepare and move providers into AAPMs**, by:
 - Replacing the Merit-Based Incentive Program with a new value-based program with a clear set of standardized meaningful quality and outcome measures. More specifically:
 - Establish streamlined, specialty specific, mandatory quality measures that prevent providers from self-selecting into quality measures they will perform best in.
 - Mandating providers move on a faster glidepath into AAPMs to ensure a meaningful and timely shift to non-fee-for-service models.
- **Establish population-based payments as the core Medicare reimbursement structure**, by:
 - Increasing CMS' authority to create prospective, population-based payments in the MPFS.
 - Creating hybrid payment models through the Medicare Physician Fee Schedule such as for primary care payment through passage of the Pay PCPs Act.
 - Mandating the Center for Medicare and Medicaid Innovation (CMMI) expands efforts to test mandatory payment models in which providers are required to participate.
 - Directing CMMI to increase the number of population-based payment models and full-risk models including global hospital budget and multi-payer models operated.

Conclusion

Thank you again for holding this hearing on better aligning the economic incentives of the health care sector with the needs of consumers and families. Ultimately, policy solutions should reorient health care payment and delivery to the goal that we all have — improved health for ourselves and our families that is affordable and economically sustainable. The journey to fully transforming our health care system is long, but Congress holds the power to take the next critical steps. Families USA stands ready to support you in this essential and urgently needed work. Please contact Jane Sheehan, Deputy Senior Director of Federal Relations at Families USA, JSheehan@familiesusa.org, for further information and to let us know how we can best be of service to you.

¹ Health Care Payment Learning & Action Network, *Alternative Payment Model APM Framework* (MITRE Corporation, 2017), <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

² Report to the Congress: Medicare and the Health Care Delivery System (Washington, DC: Medicare Payment Advisory Commission (MedPAC), June 2018), .; see also, Health Care Payment Learning & Action Network, *Alternative Payment Model APM Framework* , MITRE Corporation, 2017, <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

³ Medicare Payment Advisory Commission, *Report to the Congress: Medicare payment policy*, MedPAC, 2023 Mar, Chapter 4, physician and other health professional services, https://www.medpac.gov/wp-content/uploads/2023/03/Ch4_Mar23_MedPAC_Report_To_Congress_SEC.pdf; see also, <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-the-Primary-Care-Workforce-2025.pdf>

⁴ AHIP, *2025 APM Measurement: Progress of Alternative Payment Models*, 2026, <https://www.ahip.org/resources/2025-apm-measurement>

⁵ Laura Skopec, Robert A Berenson, Why the Medicare physician fee schedule misvalues fee levels and how to fix it, *Health Affairs Scholar*, Volume 3, Issue 10, October 2025, qxaf189, <https://doi.org/10.1093/haschl/qxaf189>

⁶ Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy, GAO-15-434, U.S. Government Accountability Office (GAO), May 2015, <https://www.gao.gov/products/gao-15-434>

⁷ Medicare Payment Advisory Commission, *Report to the Congress*, MedPAC, June 2018, Chapter 3: “Rebalancing Medicare’s Physician Fee Schedule Toward Ambulatory Evaluation and Management Services”, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf.

⁸ Medicare Payment Advisory Commission, *Report to the congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC; June 2011, Chapter 1, sustainable growth rate system, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Jun11_Ch01.pdf; see also, Robert Berenson, and Kevina Hayes, The Road to value Can’t Be Paved With A Broken Medicare Physician Fee Schedule, *Health Affairs Scholar* , Volume 43, Number 7, July 1, 2024, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00299>

⁹ Medicare Payment Advisory Commission, *Report to the Congress*, MedPAC, June 2018, Chapter 3: “Rebalancing Medicare’s Physician Fee Schedule Toward Ambulatory Evaluation and Management Services”, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf

¹⁰ Medicare Payment Advisory Commission, *Report to the Congress: Medicare payment policy*, MedPAC; 2023 Mar, Chapter 4, physician and other health professional services, https://www.medpac.gov/wp-content/uploads/2023/03/Ch4_Mar23_MedPAC_Report_To_Congress_SEC.pdf

¹¹ Health Resources and Services Administration, *State of the Primary Care Workforce*, National Center for Health Workforce Analysis, December 2025, <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-the-Primary-Care-Workforce-2025.pdf>

¹² Matthew Fiedler et al., “Congress Should Replace Medicare’s Merit-Based Incentive Payment System,” University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics, February 27, 2018, <https://healthpolicy.usc.edu/article/congress-should-replace-medicares-merit-based-incentive-payment-system/>

¹³ Aaron Mendelson et al., “The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care: A Systematic Review,” *Annals of Internal Medicine* 166, no. 5 (January 2017): 341–353, <https://www.acpjournals.org/doi/10.7326/M16-1881>.

¹⁴ AHIP, *2025 APM Measurement: Progress of Alternative Payment Models, 2026*, <https://www.ahip.org/resources/2025-apm-measurement>

¹⁵ McWilliams, J et al, “From Vision to Design in Advancing Medicare Payment Reform: A Blueprint for Population-Based Payments,” Brookings, October 13, 2021, <https://www.brookings.edu/research/from-vision-to-design-in-advancing-medicare-payment-reform-a-blueprint-for-population-based-payments/>.

¹⁶ Health Care Payment Learning & Action Network, *Alternative Payment Model APM Framework* (MITRE Corporation, 2017), <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.