

Statement for the Record

House Committee on Energy and Commerce Subcommittee on Health

Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reform

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Ann Greiner,
President and CEO,
Primary Care Collaborative

Thank you to Health Subcommittee Chairman Griffith, Ranking Member DeGette, Full Committee Chairman Guthrie, Ranking Member Pallone, and members of the House Energy and Commerce Committee for holding this important hearing today. The Primary Care Collaborative is a national nonprofit that unifies voices from across the entire health landscape to advocate for better health and wellbeing of all Americans by strengthening primary care. PCC's member organizations are united by one overarching truth: when people have access to high-quality, whole-person primary care, their health improves and costs fall—both for consumers, but also for the rest of the health system *and* taxpayers. Unfortunately, decades of reliance on flawed fee-for-service reimbursement methodologies have left primary care access at a tipping point with wait times measured in months in some geographies.¹

To change this, Medicare must move decisively to expand viable pathways beyond fee-for-service. That begins with properly valuing whole-person primary care and scaling viable primary care payment alternatives to fee-for-service.

¹ Beetham, Tamara, Trisha Marsh, Michael L Barnett, Ruby M Aaron, Emmanuel Greenberg, Alexandra Do, and Jane M Zhu. "Medicare Appointment Availability and Wait Times Vary Considerably Across Four Large US Urban Markets." *Health Affairs Scholar* 4, no. 3 (March 1, 2026): qxag054.
<https://doi.org/10.1093/haschl/qxag054>.

Decades of research have demonstrated the transformative power of primary care. The evidence suggests that strong investment in primary care promotes better outcomes,² generates savings³ and—most importantly—prevents illness, enables healthier lives and lengthens longevity.⁴

But, today, more Americans are struggling to access the primary care they need and deserve. Evidence—including the Milbank Memorial Fund’s latest Primary Care scorecard—show that about 30% of Americans don’t have a continuous relationship with a primary care team or clinician that they trust.⁵ About 27% of Americans live in a region experiencing a shortage of primary care clinicians, even more prominent in rural areas.⁶ And those who do have access to care often experience long waits for appointments or limited time with their primary care clinicians.

At the same time, more Americans are seeking care in expensive settings—including urgent care and emergency departments⁷—or deferring care altogether. Unsurprisingly, chronic conditions are on the rise, imperiling Americans health and costing taxpayers \$4.4 trillion annually⁸. In short, these access challenges have contributed to a health system that is focused on delivering high-cost, reactive treatments rather than proactive care that can prevent chronic diseases from developing.

² Mark W. Friedberg, Peter S. Hussey, and Eric C. Schneider, “Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care,” *Health Affairs* 29, no. 5 (May 1, 2010): 766–72, <https://doi.org/10.1377/hlthaff.2010.0025>.

³ Dilara Sonmez, George Weyer, and Daniel Adelman, “Primary Care Continuity, Frequency, and Regularity Associated With Medicare Savings,” *JAMA Network Open* 6, no. 8 (August 21, 2023): e2329991, <https://doi.org/10.1001/jamanetworkopen.2023.29991>.

⁴ Barbara Starfield, Leiyu Shi, and James Macinko, “Contribution of Primary Care to Health Systems and Health,” *Milbank Quarterly* 83, no. 3 (September 1, 2005): 457–502, <https://doi.org/10.1111/j.1468-0009.2005.00409.x>.

⁵ “Percentage of adults without a usual source of health care (MEPS Data).” 2026 Primary Scorecard Data Dashboard, Milbank Memorial Fund, Feb. 2026, <https://www.milbank.org/primary-care-scorecard/>.

⁶ Calculation based off of “Designated Health Professional Shortage Areas Statistics,” Bureau of Health Workforce, HRSA, accessed March 24, 2026, <https://data.hrsa.gov/topics/health-workforce/shortage-areas> and “Annual Estimates of the Resident Population for the United States”, U.S. Census Bureau, Jan. 2026, <https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html>

⁷ Centers for Disease Control and Prevention, “Trend Tables Health, United States, 2020–2021,” *Table EDAd. Emergency Department Visits Within the Past 12 Months Among Adults Aged 18 and Over, by Selected Characteristics: United States, Selected Years 1997–2019, 2021*, <https://www.cdc.gov/nchs/data/ehs/2020-2021/EdAd.pdf>.

⁸ Centers for Disease Control and Prevention, “Fast Facts: Health and Economic Costs of Chronic Conditions,” <https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html>

These access challenges are a direct result of the undervaluing of and underinvestment in primary care. Despite accounting for roughly half of all office visits,⁹ primary care accounts for less than 5 percent of all health spending—and the funding shortage is particularly acute in Medicare, where primary care is only 3.7% of spending.¹⁰

But we don't have to settle for this broken, reactive, sick-care system. And we don't have to keep building bureaucracies that burden primary care with hassles and paperwork that neither increase quality nor reduce costs. By changing how and what we pay primary care, we can ensure that care teams have the resources, infrastructure and *time* they need to spend with patients. We can empower Americans and their families to build strong, trusting relationships with clinicians who understand *all* their health needs and partner with them to effectively manage them.

SUMMARY OF POLICY RECOMMENDATIONS

- 1) **Properly Value Primary Care**: Congress must address the persistent undervaluation of primary care that drives inadequate investment in primary care. It is also vital that CMS explore alternative data sources, beyond surveys, to gain a more complete understanding of the value of different services. Pairing stronger investment with proper valuation going forward can help reverse trends that have contributed to workforce shortages exacerbating access issues across the nation.
- 2) **Implement Hybrid Payments**: Congress should pair stronger investment in primary care with a smarter approach to payment by implementing hybrid payments, as recommended by the National Academies of Science, Engineering and Medicine.¹¹ Hybrid payments provide primary care with fixed, regular upfront payments to help meet usual health needs of their patients—such as preventing chronic disease and chronic disease complications—while also providing additional fees for high-value, underprovided services. Shifting away from the broken fee-for-service chassis is essential if policymakers want to focus on promoting better health by fostering whole-person care. Primary care-focused ACO models and partnerships in Medicare Advantage—many enabled

⁹ “National Ambulatory Medical Care Survey: 2019 National Summary Tables”, Centers for Disease Control, 2019, https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2019-namcs-web-tables-508.pdf

¹⁰ Milbank Memorial Fund, “2026 Primary Care Scorecard Data Dashboard | Milbank Memorial Fund.”

¹¹ National Academies Of Sciences Engineering, And Medicine, “Implementing High-Quality Primary Care,” (*The National Academies Press*, May 4, 2021), <https://doi.org/10.17226/25983>.

with alternative payment models—show improvements in quality while slowing costs.¹²

- 3) **Reform and Cut Red Tape in MIPS:** Policymakers must address burdensome red tape created by the MIPS program by simplifying and refocusing quality metrics on what matters, including continuity of relationships and comprehensiveness of services. Developing a simpler, and where possible outcome-focused, approach to quality measures—and potentially aligning with other payers—could help eliminate hours of unnecessary paperwork.
- 4) **Eliminate Cost Sharing for Primary Care:** Finally, Medicare beneficiaries need your help to remove unnecessary cost-sharing barriers to primary care. These barriers to care create administrative friction, places needless financial burdens on accessing high-value care for American families and prevent far too many people on Medicare from seeking the type of preventive care essential to better health. Eliminating these barriers is particularly important for expanding care management and integrated behavioral health services, which play a critical role in keeping people healthy.
- 5) **Ensure Whole Person Care:** Primary care should be comprehensive, coordinated and relationship-based. To support patients in successfully achieving their health goals, practices must have the resources and staff to respond, address and coordinate physical, behavioral and social care across multiple settings. Stronger primary care teams should include behavioral health clinicians, pharmacists, social workers and care managers capable of supporting patients with chronic disease and behavioral health - and connect them to social care and community resources.

1) Properly Value Primary Care

The PCC believes the Medicare Physician Fee Schedule (MPFS) structurally disadvantages primary care by systematically overvaluing procedures, imaging and testing while undervaluing cognitive, relationship-based, time-intensive services. This

¹² Primary Care Collaborative, “Make Medicare Beneficiaries Healthier by Strengthening Primary Care,” (March 2025), <https://thepcc.org/wp-content/uploads/2025/03/Make-Medicare-Beneficiaries-Healthier-Issue-Brief.pdf>.

mis-valuation contributes to primary care workforce instability, practice closures and worsening access to care.

Medicare reimburses physicians 3 to 5 times more for common procedures than for cognitive-focused care,¹³ even though primary care clinicians manage complex chronic disease, coordinate care across multiple settings and support long-term patient relationships.

Current valuation methods rely too heavily on outdated survey data, fail to account for procedural efficiency gains and overlook the growing complexity of chronic disease management and the importance of sustaining continuous patient relationships in primary care. MPFS reform is necessary to rebalance value toward time and relationships and to better support prevention, behavioral health integration and chronic disease care.

The PCC supports reforms implemented by the CY 2026 Medicare Physician Fee Schedule, including the efficiency adjustment, greater use of empirical data and a site-of-service differential favoring community-based practices and asks policymakers to continue to build upon these important reforms in 2027.

Along with these investments, PCC believes Medicare’s budget-neutrality requirements undermine meaningful investment in primary care because increases in primary care reimbursement often require offsetting cuts elsewhere in the Physician Fee Schedule. The zero-sum budget-neutrality requirements applicable to the Physician Fee Schedule should not undermine the scope and viability of substantial reforms. To invest more robustly in primary care without forcing reductions in other primary care services, Congress must update the MPFS budget neutrality threshold to reflect inflation. This threshold has been set at \$20 million and has not been adjusted since its establishment in the 1990s. We urge lawmakers to require that this threshold be adjusted automatically going forward. Congress should also address persistent overestimation issues by instructing CMS to revisit assumptions used in calculating budget neutrality adjustments retroactively. Additionally, to meet its oversight responsibilities, Congress should direct the Government Accountability Office to compare CMS utilization estimates for new Medicare codes with actual utilization and payments after implementation, and to report its findings to Congress by a specified deadline.

¹³ Sinsky, Christine A, and David C Dugdale. “Medicare payment for cognitive vs procedural care: minding the gap.” *JAMA internal medicine* vol. 173,18 (2013): 1733-7. doi:10.1001/jamainternmed.2013.9257

2) Implement Hybrid Payment Models

The PCC believes fee-for-service payment discourages prevention, care coordination and comprehensive chronic disease management because it rewards volume, particularly of higher priced services, rather than longitudinal patient relationships. That is why the PCC has encouraged Congress and the Administration to make hybrid payments available to primary care.

While we are grateful that the CMS Innovation Center has made important strides by rolling out models testing hybrid payments, we encourage Congress and Medicare to explore how to make hybrid payments broadly available across the permanent Medicare program.

The PCC's vision for hybrid payment is to combine upfront payments with ongoing fee-for-service reimbursement for selected services, enabling clinicians to build multidisciplinary care teams and spend more time with patients. This model supports services often left uncompensated or undercompensated under fee-for-service, including care coordination, behavioral health integration, patient communication, nutrition counseling and community-based support.

This approach, if properly resourced:

1. Provides more stable funding needed to attract and retain primary care clinicians;
2. frees clinicians to spend more time with patients by minimizing incentives that have led to squeezing more and more patient visits into the workday;
3. and allows primary care to build out care teams capable of delivering care for the whole person, including mental health, nutrition and lifestyle change.

PCC supports transitioning Medicare primary care payments from a predominantly fee-for-service approach to prospective, appropriately resourced population-based/hybrid payment models and to capitation for those practices ready to accept such risk.

3) Reform and Cut Red Tape in MIPS

While PCC supports the underlying goal of shifting from fee-for-service to value-based care that led to the establishment of Merit-based Incentive Payment System (MIPS), the reality is that, today, MIPS is a barrier to achieving that goal.

The wide swathe of measures—which rarely align with quality reporting for other payers—present a significant burden on primary care. These administrative reporting tasks eat up valuable time that would better be spent with patients and contribute to clinician burnout, ultimately exacerbating existing access issues.

The first, most immediate task is to provide relief from these burdens. Congress should minimize MIPS reporting requirements for those primary care teams participating in value-based care by reducing reporting requirements for clinicians participating in Alternative Payment Models or adopting Advanced Primary Care Management (APCM) codes.

Looking ahead, PCC urges Congress and the Administration to explore still more ambitious steps to simplify and streamline performance measurement. Working to align measures with private payers and across federal programs would help eliminate redundancy and simplify the red tape primary care must navigate while filing claims.

Finally, it is essential to develop metrics that measure health and those characteristics of care that are most strongly associated with health, like continuity and comprehensiveness of primary care.

4) Eliminate Cost-Sharing for Primary Care Services

Beneficiary cost-sharing creates unnecessary barriers to primary care, including behavioral health care and chronic disease management. Applying coinsurance to services such as APCM, behavioral health integration and chronic care management discourages uptake and adds administrative complexity for practices.

PCC supports waiving cost-sharing for services covered under hybrid payment arrangements and removing financial barriers to behavioral health integration and chronic disease management codes. By reducing cost-sharing, beneficiaries would be encouraged to seek upstream care earlier and more consistently, improving outcomes and reducing downstream spending.

The development and introduction of legislation to remove cost-sharing for APCM and associated behavioral health integration add-on codes would be an essential step toward increasing access to primary care.

5) Ensure Whole-Person Primary Care

The PCC believes behavioral health integration is essential to effective whole-person primary care because behavioral health conditions frequently co-occur with chronic

physical illness and significantly increase total health care spending. Nearly 1 in 4 Medicare beneficiaries lives with a mental illness, and that 75% of primary care visits include behavioral or mental health components.

Evidence-based models, such as the Collaborative Care Model and the Primary Care Behavioral Health model, can improve depression outcomes, reduce emergency department utilization, and strengthen chronic disease management.

Yet Medicare's existing behavioral health integration codes have seen low uptake because of burdensome time-tracking requirements, insufficient reimbursement and beneficiary co-pays.

The PCC supports enhanced reimbursement, technical assistance and elimination of cost-sharing to make integrated care financially viable for primary care practices, particularly in rural and underserved communities.

As a first step toward the accelerated adoption of integrated care, the PCC urges this Committee to mark-up and report HR. 2509, the COMPLETE Care Act.

The PCC and our members are grateful to the Committee for their efforts to improve Americans' health by strengthening the Medicare program, and we appreciate the chance to demonstrate why centering primary care must be central in those efforts.

The PCC and its members stand ready to work with Congress to develop solutions that provide Medicare beneficiaries with the high-quality, whole-person primary care that they deserve.