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ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
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May 18, 2026

MEMORANDUM

To: Subcommittee on Health Members and Staff
From: Committee on Energy and Commerce Majority Staff
Re: Subcommittee on Health Hearing on May 20, 2026

I. INTRODUCTION

The Subcommittee on Health will hold a hearing on Wednesday, May 20, 2026, at 2:00 p.m. (ET) in 2123 Rayburn House Office Building. The hearing is entitled "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms."

II. WITNESSES

- **William Fox, MD, MACP,** Chair Emeritus, American College of Physicians Board of Regents, Fox & Brantley Internal Medicine
- **Steven Furr, MD, FAAFP,** Family Medicine Physician
- **Dana Smetherman, MD, MPH, MBA, FACR,** Chief Executive Officer, American College of Radiology
- **Rick Snyder, MD,** President, HeartPlace
- **Farzad Mostashari, MD,** Chief Executive Officer and Co-Founder, Aledade

III. BACKGROUND

This hearing will build on the Committee's third health affordability series hearing on the provider landscape by examining the Medicare physician fee schedule (PFS), reforms enacted in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and opportunities for Medicare physician payment reform.[1]

During the March 18 hearing, several Members of the Committee, as well as witnesses testifying before the Subcommittee, highlighted consolidation in the provider sector as one factor

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[1] *See*, *Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape: Hearing before the Subcomm. on Health of the H. Comm. on Energy and Commerce,* 119th Cong. (Mar. 18, 2026).

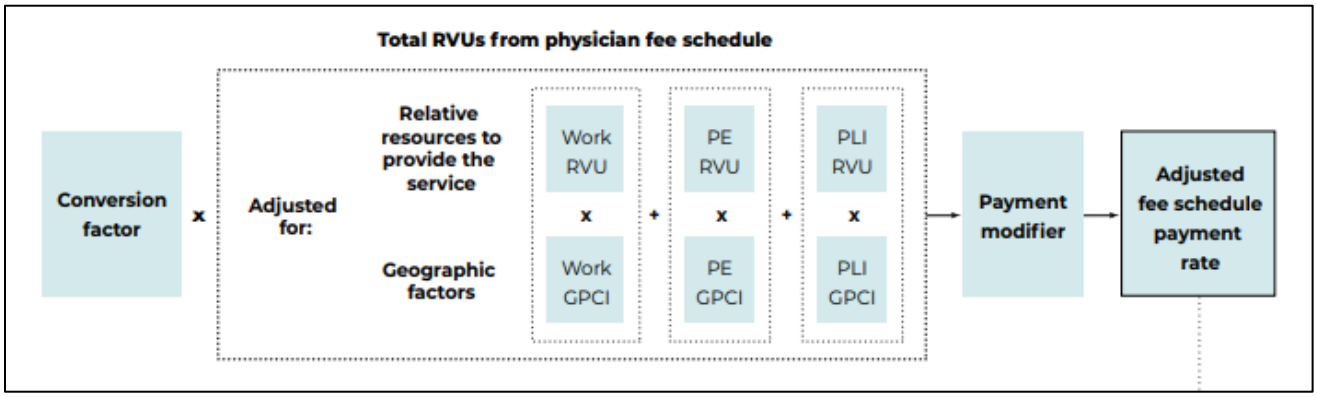
that may drive higher health care costs for patients and payors. This consolidation has become increasingly prevalent. According to the Government Accountability Office, in 2024, at least 47 percent of U.S. physicians were employed by, or affiliated with, hospital systems—up from less than 30 percent in 2012.[2]

Several statutory, regulatory, or market incentives may influence a physician or other health professionals' decisions to become employed by, or affiliated with, a health system or other entity. One key issue identified by witnesses at the hearing, however, is the role played by the Medicare PFS in establishing payment rates for providers. Other noted issues relate to how various regulatory structures in the Medicare program can place significant administrative burden on physicians and other health professionals.

Despite attempts in MACRA to move past the need for Congress to enact semiannual or annual "doc fixes" and toward a system focused on driving efficient and high-quality care, many of these challenges persist. This strain placed on providers, resulting from payment uncertainty and regulatory complexity, affects the ability of these practitioners to furnish care. This hearing will examine these long-standing challenges and work to identify solutions to stabilize physician payment, as well as protect and improve seniors' access to care.

A. Medicare Physician Fee Schedule

Medicare plays an important role in influencing payment rates for physicians and other health professionals across the health care system. Under fee-for-service Medicare, the program pays for services furnished by these practitioners at payment rates established under the PFS. According to the Medicare Payment Advisory Commission (MedPAC), in 2024, the Medicare PFS paid for approximately 9,000 services, ranging from office visits and surgical procedures to imaging and tests.[3]



Medicare PFS payment rates are determined based on relative value units (RVU), which are intended to reflect the relative costliness or intensity of the clinician service and its various

[2] GOVERNMENT ACCOUNTABILITY OFFICE, *Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation*, GAO-25-107450 at 16 (Sept. 22, 2025), https://files.gao.gov/reports/GAO-25-107450/index.html.
[3] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy, Chapter 4: Physician and other health professional services* at 99 (Mar. 12, 2026), https://www medpac.gov/wp-content/uploads/2026/03/Mar26_Ch4_MedPAC_Report_To_Congress_SEC.pdf.

inputs. These RVUs are subdivided into three categories to account for professional work, practice expense, and professional liability insurance:[4]

- *Work RVUs* account for the clinician's time and the professional skill involved in furnishing the service.
- *Practice Expense RVUs* account for direct and indirect costs of furnishing the service, including staff, equipment, supplies, and a practice's overhead.
- *Professional Liability RVUs* account for medical liability insurance costs.[5]

Once these RVUs, which are adjusted by geographic indexes, are established, they are multiplied by a conversion factor that ultimately yields a payment rate for the service.[6] The conversion factor is currently updated based on a statutory schedule established in MACRA and further adjusted for any budget-neutrality adjustments.

	2021	2022	2023	2024	2025	2026	2027
Updates							
Clinicians in A-APMs	—	—	—	—	—	0.75%	0.75%
Clinicians not in A-APMs	—	—	—	—	—	0.25%	0.25%
All clinicians *(not cumulative)*	3.75%	3.0%	2.5%	1.25%, 2.93%	—	2.5%	—

Under MACRA, beginning in 2026, the statute specifies PFS conversion factor updates of 0.75 percent for clinicians participating in advanced alternative payment models (APM) and 0.25 percent for other clinicians. For calendar year 2026, the Centers for Medicare & Medicaid Services (CMS) finalized a 3.77 percent update for qualifying APM participants and a 3.26 percent update for non-qualifying APM participants. This reflects MACRA's split conversion factor updates of 0.75 percent and 0.25 percent, an estimated 0.49 percent adjustment to both conversion factors to account for work RVU changes, and a one year, 2.5 percent update to both conversion factors enacted as part of the Working Families Tax Cuts.[7]

As noted, under current law, CMS is required to calculate and effectuate a budget-neutrality adjustment to the PFS yearly to account for changes made to specific billing codes' such that these modifications do not increase or decrease total fee schedule spending by more than $20 million.[8] While other Medicare payment systems have similar budget-neutrality requirements,[9] stakeholders have continually raised concerns about the PFS's lack of an

[4] MedPAC, *Payment Basics: Physician and Other Health Professional Payment System* at 1-2 (Nov. 2025), https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_Physician_FINAL_SEC.pdf.
[5] American Medical Association, *Understanding Relative Value Units (RVUs)* (Dec. 5, 2025), https://www.ama-assn.org/practice-management/cpt/understanding-relative-value-units-rvus.
[6] *Nov. 2025 MedPAC*, *supra note 4.*
[7] CTRS. FOR MEDICARE & MEDICAID SERVICES (CMS), Fact Sheet, *Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F)* (Oct. 31, 2025), https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f; *see also,* Working Families Tax Cuts, Pub. L. No. 119-21, § 71202 (2025).
[8] *March 2026 MedPAC, supra note* 3, at 134-135.
[9] *Id.* at 135.

inflation-based yearly update—contending that this structure places PFS investments toward one specialty in competition with other specialties.[10]

B. Medicare Access and CHIP Reauthorization Act of 2015

MACRA was signed into law on April 16, 2015, enacting significant bipartisan reforms to Medicare physician payment, among other provisions.[11] Notably, MACRA permanently repealed the Sustainable Growth Rate (SGR) formula and aimed to shift Medicare payment for clinicians from a fee-for-service, volume-driven system to a program that rewards quality and value through the implementation of the Quality Payment Program (QPP).

Sustainable Growth Rate

The SGR formula was enacted as part of the Balanced Budget Act of 1997, replacing the Medicare Volume Performance Standard.[12] This formula was used to establish yearly target expenditures for Medicare physician services. As noted by CMS, the "SGR targets [were] not direct limits on expenditures."[13] Instead, SGR targets were compared to actual expenditures. The difference in cumulative actual expenditures versus cumulative SGR target expenditures was used to establish the upcoming year's conversion factor for the PFS. The SGR formula was comprised of four factors:

- The estimated percentage change in fees for physicians' services.
- The estimated percentage change in the average number of Medicare fee-for-service beneficiaries.
- The estimated 10-year average annual percentage change in real gross domestic product per capita.
- The estimated percentage change in expenditures due to changes in law or regulations.

In the initial years following the SGR formula's implementation, actual expenditures did not exceed SGR target expenditures and resulted in positive conversion factor updates for the following year.[14] However, this changed beginning in 2002, when actual expenditures exceeded the SGR target.[15] Because the SGR formula compared cumulative expenditures, as Congress began to delay these cuts—often enacting short-term "patches" to impending payment cuts required by the formula—the future cut grew.

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[10] Christopher P. Childers et al., *Modernizing The Medicare Physician Fee Schedule: What Problem Are We Trying to Solve?,* Health Affairs (May 8, 2026), https://www healthaffairs.org/content/forefront/modernizing-medicare-physician-fee-schedule-problem-we-trying-solve.
[11] Evelyne P. Baumrucker, et al., CONG. RSCH. SERV. (CRS), R43962, The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10) at 4 (Nov. 10, 2015); *see also* Medicare Access and CHIP Reauthorization Act of 2015, P.L. 114-10, (2015).
[12] CMS, *Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2015* at 1 (Apr. 2014), https://www.cms.gov/medicare/medicare-fee-for-service-payment/sustainablegratesconfact/downloads/sgr2015p.pdf.
[13] *Id.*
[14] Jim Hahn, CONG. RSCH. SERV. (CRS), R43430, The Sustainable Growth Rate (SGR) and Medicare Physician Payments: Frequently Asked Questions at 1 (Mar. 16, 2015).
[15] *Id.*

Members of Congress, stakeholders, and researchers heavily criticized the SGR formula. Potential SGR cuts created significant instability for physicians and other health professionals due to uncertainty about payments and whether, and how, Congress would override these cuts. At the time of MACRA's passage to permanently repeal the SGR formula, absent congressional action, the projected cut would have been approximately 21 percent.[16]

In addition to the repeal of the SGR, MACRA also aimed to reduce PFS payment instability by codifying specified updates to the conversion factor beginning in 2016. For calendar years 2016-2019, MACRA provided conversion factor updates of 0.5 percent, a 0 percent update for 2020-2025, and beginning in 2026, a split conversion factor update of 0.75 percent or 0.25 percent dependent on whether the provider participated in a qualifying APM.[17] Despite these efforts, between 2020 and 2023, and most recently in 2025, Congress acted numerous times to provide further payment stability for physicians and health professionals through one-time conversion factor updates.[18]

Quality Payment Program

MACRA also established the Quality Payment Program (QPP), which was designed to reward physicians who provided the highest quality of care with financial incentives and reduced payments to physicians who fell short of the program's goals. QPP provided two ways for clinicians to participate:[19]

- Merit-based Incentive Payment System (MIPS); and
- Advanced APMs.

MIPS consolidated elements of the Physician Quality Reporting System, Meaningful Use, and value-based payment modifier.[20] MIPS was implemented in 2019 and measures the performance of MIPS eligible clinicians based on four performance categories:[21]

- Quality (weighted at 30 percent of final score);
- Improvement Activities (weighted at 15 percent of final score);
- Promoting Interoperability (weighted at 25 percent of final score); and
- Cost (weighted at 30 percent of final score).

MIPS eligible clinicians' performance across these categories results in a MIPS final score or a composite performance score, which measures against an established performance threshold.[22] Whether the clinician receives a positive, neutral, or negative payment adjustment of

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[16] Baumrucker, *supra* note 11, at 3.
[17] MedPAC, *Reforming physician fee schedule updates and improving the accuracy of relative payment rates* at 2 (Apr. 10, 2025), https://www medpac.gov/wp-content/uploads/2025/04/Tab-C-PFS-reform-April-2025.pdf.; *see also* the Balanced Budget Act of 2018, which reduced the calendar year 2019 conversion factor updated to 0.25 percent.
[18] *April 2025 MedPAC, supra* note 17, at 2.
[19] CMS, Quality Payment Program, *What's the Quality Payment Program?* (Sept. 10, 2024), https://www.cms.gov/medicare/quality/value-based-programs/quality-payment-program.
[20] Baumrucker, *supra* note 11, at 4.
[21] CMS, Quality Payment Program, *Compare Reporting Requirements*, https://qpp.cms.gov/reporting-requirements/ways-to-report/compare (last accessed May 15, 2026).
[22] Baumrucker, *supra* note 11, at 7.

up to 9 percent in a payment year corresponds to whether that clinician's final score falls above, equal to, or below the performance threshold in a given performance year. These payment adjustments apply in the second calendar year following the performance year (e.g., the 2026 performance year corresponds to the 2028 payment year).[23]

A provider's MIPS eligibility status is determined by several factors, including when the individual first enrolled as a Medicare provider, the type of clinician, and the volume of Medicare services furnished, as well as whether a clinician participates in an advanced APM and meets the thresholds for Qualifying APM Participant (QP) status.[24] CMS estimates that there are 607,419 MIPS eligible clinicians for the 2026 performance period/2028 MIPS payment year.[25]

Since MIPS was enacted in MACRA and continuing following its implementation, various stakeholders and researchers have raised concerns with the program, such as MedPAC, which has recommended eliminating the program.[26] One literature review synthesizing academic and other third-party literature on the impact of MACRA found that MIPS has not necessarily led to improvements in quality or decreases in spending and has instead created administrative burden for physicians.[27]

As CMS recently noted, however, MACRA was a "paradigm shift" in that it repealed the SGR and attempted to move Medicare toward more value-based care through the QPP.[28] Agency officials also stated that MIPS is unique in comparison to other quality programs due to its volume of participating clinicians across a range of specialties and practice types, sizes, and levels.[29] CMS also sought to address some concerns associated with MIPS—such as those around reporting burden and a lack of specialty care measures—through the introduction of MIPS Value Pathways (MVP).[30] To date, 27 MVPs have been finalized and are available for performance year 2026 across various specialties.[31]

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[23] CMS, Quality Payment Program, *Merit-based Incentive Payment System (MIPS): Traditional MIPS Scoring Guide for the 2026 Performance Year* at 7, https://d2g5m5leph8kam.cloudfront.net/s3fs/s3fs-public/2026-04/2026-Traditional-MIPS-Scoring-Guide.pdf?VersionId=nk2MYLLH2IFx_8s4wtIhW_EhXre5UHYh (last accessed May 15, 2026).

[24] CMS, Quality Payment Program, *How is Eligibility Determined?* https://qpp.cms.gov/eligibility-participation/eligibility/determination?py=2026 (last accessed May 15, 2026).

[25] Final rule, 90 Fed. Reg. 49266 (Nov. 5, 2025) (Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program) at 49981 (Table D-B14).

[26] MedPAC, *March 2018 Report to the Congress: Medicare Payment Policy, Chapter 15: Moving beyond the Merit-based Incentive Payment System* at 445 (Mar. 15, 2018), https://www medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch15_sec.pdf.

[27] Zack Cooper et al., *Review of the Expert and Academic Literature Assessing Impact of Medicare Access and CHIP Reauthorization Act of 2015*, Yale Tobin Center For Economic Policy at 2 (April 13, 2023), https://tobin.yale.edu/sites/default/files/2023-06/20230413_MACRA%20Literature%20Review_0.pdf.

[28] Michelle Schreiber & Dora Lynn Hughes, *A Vision For MIPS's Next 10 Years: Short-Term Changes, Long-Term Strategy Development*, Health Affairs (Apr. 14, 2026), https://www.healthaffairs.org/content/forefront/vision-mips-s-next-10-years-short-term-changes-long-term-strategy-development.

[29] *Id.*

[30] *Id.*

[31] CMS, Quality Payment Program, *Explore MIPS Value Pathways (MVPs)*, https://qpp.cms.gov/reporting-requirements/measures-activities/explore-mvps (last accessed May 15, 2026).

In addition to MIPS, MACRA also sought to move Medicare fee-for-service beneficiaries into APMs by encouraging more providers to participate in new care delivery models. MACRA defined APMs to include:[32]

- A model under the Center for Medicare & Medicaid Innovation;
- A Medicare Shared Savings Program accountable care organization;
- A demonstration under section 1866C of the Social Security Act; or
- A demonstration required by federal law.

To incentivize participation in APMs through Medicare, MACRA established certain incentive payments for QPs in advanced APMs. These incentives included bonus payments equal to 5 percent of fee schedule payments in payment years 2019-2024, 3.5 percent in payment year 2025, and 1.88 percent in 2026.[33] Congress also provided a 3.1 percent bonus payment for the 2028 payment year in the recently enacted Consolidated Appropriations Act, 2026.[34] As noted, beginning in calendar year 2026, QPs will also receive the higher conversion factor update of 0.75 percent compared to 0.25 percent for non-QPs.

In general, QP or partial QP status is determined by eligible clinicians' volume of Medicare Part B payments or the percentage of Medicare patients for which they care through an Advanced APM Entity.[35] The thresholds for these statuses change according to statutory requirements, though Congress has modified these thresholds over time. QPs and partial QPs are not required to report under MIPS.[36]

In MedPAC's June 2024 report, the Commission stated that the number of clinicians qualifying for the bonus has increased since 2019, though only one in five clinicians billing Medicare fee-for-service received a bonus in 2023.[37] The size of APM participation bonuses vary based on the volume and scale of a clinicians' Medicare payments.[38] Some participants in an advanced APM may still be ineligible for the bonus if they do not otherwise meet criteria to be considered a QP or do not take on sufficient financial risk, for example.[39] Academic and third-party research have found some evidence that APMs can lead to savings without affecting quality, though these savings vary by model or program.[40]

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[32] *Baumrucker, supra note 11,* at 10.
[33] MedPAC, *Considering the participation bonus for clinicians in advanced alternative payment models* at 6 (Nov. 7, 2024), https://www medpac.gov/wp-content/uploads/2023/10/APM-bonus-Nov-2024-slides_SEC.pdf.
[34] Consolidated Appropriations Act, 2026, Pub. L. No. 119-75.
[35] CMS, Quality Payment Program, *Advanced APMs*, https://qpp.cms.gov/eligibility-participation/apm/advanced-apms (last accessed May 15, 2026).
[36] *Id.*
[37] MedPAC, *June 2024 Report to Congress: Medicare and the Health Care Delivery System, Chapter 1: Approaches for updating clinician payments and incentivizing participation in alternative payment models* at 16 (Jun. 13, 2024), https://www medpac.gov/wp-content/uploads/2024/06/Jun24_Ch1_MedPAC_Report_To_Congress_SEC.pdf.
[38] *Id.* at 16-17.
[39] *Id.* at 17.
[40] *Cooper, supra note 27.*

IV. KEY QUESTIONS

The hearing may include discussion of the following key questions:

- What policies should Congress consider to address payment uncertainty and instability in the Medicare PFS, including targeted reforms to improve the structure and rate-setting methodology of the fee schedule?

- How can Congress build on reforms enacted in MACRA to encourage more providers to move away from fee-for-service reimbursement and toward APMs?

- What steps could be taken to improve MIPS and APMs' quality measurement, model design, or programmatic structure to enhance its relevance for clinicians and reduce barriers to participation for independent practices, specialists, and subspecialists?

- How can the administrative complexity and reporting burden for clinicians participating in MIPS or APMs be reduced?

V. STAFF CONTACTS

If you have questions regarding this hearing, please contact Claire Richey of the Committee staff at (202) 225-3641.