AMERICAN ACADEMY *of* FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

Steven Furr, MD, FAAFP
Family Physician and Co-Founder,
Family Medical Clinic of Jackson

To

House Committee on Energy and Commerce
Health Subcommittee

On

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

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1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033

www.aafp.org

Chairman Griffith, Ranking Member DeGette, and distinguished members of the Subcommittee, thank you for the opportunity to testify today. My name is Steven Furr, MD, FAAFP and I am a practicing family physician from Jackson, Alabama. I am a co-founder of Family Medical Clinic of Jackson, a rural health clinic, as well as a member of the medical staff for a small rural hospital and medical director of the local nursing home. As a Past President of the American Academy of Family Physicians (AAFP), I am honored to be here today representing the more than 124,500 physician and student members of the AAFP.

As a family physician who has cared for patients for more than 35 years, I can speak firsthand about how our flawed Medicare physician payment system has perpetuated underinvestment in primary care, overwhelmed physicians with administrative burdens, and contributed to the decline of private practice – all of which has direct consequences for patients and the care they receive.

As a nation, we are at a crossroads with our health care and outcomes. Compared to other high-income peer nations, the U.S. has higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.[i] Nearly 95 percent of American adults 60 years and older have at least one chronic condition, and nearly 80 percent have two or more.[ii] But family physicians, through the delivery of continuous, coordinated, and comprehensive primary care, are uniquely well-suited to care for, manage, and prevent these conditions at the patient and population level.

Evidence has shown that health systems that invest more heavily in primary care consistently achieve better population health outcomes, lower rates of hospitalization and emergency department use, and lower overall health care spending. Yet despite its central role, the United States invests far less in primary care than many other high-income countries. Only about five to seven percent of total U.S. health care spending is spent on primary care, a share that has been declining over time. In 2022, primary care spending dropped to less than five cents of every dollar, with Medicare spending the lowest at 3.4 percent.[iii]

This declining investment is attracting fewer prospective physicians to practicing primary care and contributing to a troubling trend: a growing number of Americans report not having a usual source of care. The number of American adults who do not have a usual source of care is the highest it has been in a decade of measurement, with almost a third (31 percent) reporting that they had no usual source of care in 2022.[iv]

Effectively meeting the current and future needs of our patients requires our nation to better leverage primary care as the foundation of our health care system. However, our current fee-for-service payment structure favors and incentivizes work that is done *to* a patient, rather than done *with* and *for* them. We need doctors who care for people, not doctors to deliver services.

Decades of systemic underinvestment in primary care and prevention have led to poorer population health and a greater emphasis on sick care, rather than health care. We as a nation have worried about increased upfront spending and implemented policies that have wrongly steered people away from high-value, low-cost services like preventive screenings and primary care office visits. By failing to invest more upfront dollars in primary care, we're paying an even higher price. We're spending more than ever on health care costs, both as a nation and as consumers, because we have sicker patients receiving later diagnoses and utilizing expensive settings like the emergency room and hospital as their usual source of care.

Establishing a health care system that prioritizes primary care will, among many other things, require a meaningful overhaul of physician payment that will take time. However, as a starting point, I urge Congress to consider policies that work toward the following objectives:

- **More appropriately valuing the work of primary care within the Medicare Physician Fee Schedule**, which is the framework for many value-based payment arrangements;
- **Reforming budget neutrality requirements** that unnecessarily pit physician specialties against one another while undermining CMS' ability to invest in *all* the services a patient may need;
- **Addressing existing financial barriers that dissuade patients' utilization of chronic care management and other primary care services** by waiving cost sharing responsibilities; and
- **Providing primary care physicians and practices with more prospective, sustainable revenue streams** that allow them to tailor the care they deliver to their patient's needs.

Reforming Fee-for-Service to Better Value Primary care

One of the major factors contributing to underinvestment in primary care is the relative undervaluation of primary care in fee-for-service (FFS), the predominant payment model. In general, the Medicare Physician Fee Schedule (MPFS) values procedural services delivered by other specialists higher than it does office visits and other cognitive services, which are more commonly delivered by primary care physicians. Primary care and other work has been passively devalued over time as many new procedural codes with higher values have been added.[v]

This devaluation has led to lower compensation for primary care physicians who specialize in treating the whole person compared to our specialist peers, despite the vital role we play in managing chronic conditions and coordinating patient care across a large team and despite the fact evidence has shown that primary care office/outpatient evaluation and management (E/M) visits are more complex and comprehensive than those delivered by other specialties. [vi] This devaluation is not limited to Medicare. Many other private and public payers peg their payment rates to the MPFS rates or use the relative values in the MPFS to set their rates.

Further, FFS doesn't just underinvest in primary care – it also makes it extremely complex to get paid. We must submit unique codes for each and every service we provide – documenting both what we did and why we did it. This is incompatible with the continuous, comprehensive nature of primary care which spans everything from basic preventive services to more complex services involving chronic care management, integrated behavioral health, and care coordination. For patients with chronic conditions, these discrete services may include patient education, care planning, and managing medications, all of which are ongoing and continuous processes. Each of these services must be individually documented to justify payment for typical, comprehensive primary care, even though these services are all foundational aspects.

The retrospective, volume-based nature of FFS also fails to account for the costs of longitudinally managing patients' overall health. It does not provide practices with the time and flexibility to invest in the care management staff and population health tools that enable practices to efficiently and effectively meet patients' individual evolving health needs. For example, FFS structures have not historically paid for wraparound patient activities, such as community health workers or care

coordination, but these interventions enable family physicians to better address a patient's identified health-related social needs (HRSNs) within a patient's community context. This disadvantages patients who require more support and the physicians who care for them. While Medicare implemented new codes for some of these services in 2024, such as community health integration, their utilization and effectiveness is not yet known.

For these reasons, the AAFP has long advocated to accelerate the transition to value-based care using alternative payment models (APMs) that provide prospective, population-based payments to support the provision of comprehensive, longitudinal primary care. We strongly believe well-designed APMs provide primary care a path out of the under-valued and overly burdensome FFS payment system that exists today, and in turn will better enable the Medicare program to meet the needs of its growing and aging beneficiary population in new and innovative ways. Unfortunately, a dearth of primary care APMs and the inadequacy of FFS payment rates that often underlie APMs are undermining the transition to value-based care. Because most APMs are designed based on FFS payment rates, modernizing FFS payment for primary care is one essential strategy to support physicians' transition into value-based care.

Therefore, while FFS is not the future the AAFP envisions for primary care, it is the present. Federal policymakers must ensure the current FFS system appropriately and sustainably compensates primary care physicians to make more meaningful progress toward the future – one that rewards value over volume of services.

We have been encouraged by recent regulatory policy changes aimed at more appropriately valuing and paying for primary care and other types of cognitive care in Medicare. These incremental steps have included implementation of new codes to pay for work that was not previously captured by existing codes, providing monthly bundled payments for care management services with the advanced primary care management (APCM) codes, and
using other empirical data sources to more accurately estimate the time it takes physicians to provide certain services and updating their associated relative value units accordingly.

However, the impacts of these positive policy changes are blunted by existing statutory requirements. For example:

- Extremely restrictive budget neutrality requirements – which haven't been updated since the inception of the MPFS – mean that, in most cases, new codes cannot be added without triggering an across-the-board payment cut to all services. If CMS increases the valuations of any codes, it also means that the valuations of other codes must be reduced or the conversion factor is cut.
- The budget-neutral nature of the MPFS also means that the Merit-based Incentive Payment System (MIPS), which was intended to move more physicians successfully into value-based payment, has failed to achieve its intended goal. Penalties applied to "low-performing" clinicians pay for the awards provided to high-performers, creating a cycle whereby small, independent, and rural practices are consistently punished instead of offered a necessary helping hand.
- And finally, all of this is happening within the same pot of money that has existed since 1992 – despite a growing beneficiary population, increasing costs of running a practice, and significant innovations in medicine over the last several decades leading to more services and technologies

being added to the MPFS. This policy framework has forced physician specialties to compete against each other for smaller and smaller pieces of the pie each year.

Ensuring widespread access to high-value, lower-cost primary care requires us to change how we pay for it. We need to pay family physicians for preventing disease, not incentivizing the delivery of more services to treat it. Comprehensively reforming Medicare payment for primary care must be a priority for Congress. I want to thank Drs. Joyce, Miller-Meeks, Ruiz and Schrier on the Subcommittee for their steadfast leadership on these issues, and I urge Congress to:

- Provide an annual inflationary update to physician payment. There is no justification for why facilities like hospitals and skilled nursing facilities receive an annual update, but the physicians – those of us actually providing care – do not. Payment for physicians is on an increasingly unsustainable path. Not receiving an inflationary-based update is only compounded by the fact that practices like mine continue to face a two percent cut on all Part B payments due to sequestration. If we think health care costs are out of control now, it will only get worse unless Congress acts to ensure that the work we do is adequately compensated and keeps pace with the actual costs required to deliver care.
- Enact long-overdue reforms to budget neutrality requirements. This includes providing CMS with the authority to correct over- or under-utilization assumptions when implementing new codes, ensuring that funds within the fee schedule are not irreversibly lost due to inaccurate assumptions. The AAFP supports the *Provider Reimbursement Stability Act* (H.R. 8163) which would advance such reforms.
- Make quality measurement more meaningful to physicians and patients. Family physicians are disproportionately accountable for a growing number of disease-specific process measures that fail to capture the true nature and value of comprehensive, patient-centered primary care. While quality measurement is essential for moving toward a value-based system, our current approach fails to measure what matters to patients and clinicians or drive meaningful quality improvement. We must standardize quality and performance measures with a single universal set – across payers and programs – that meets the highest standards of validity and reliability and is derived from data extracted from multiple data sources. The measures should focus on outcomes that matter most to patients and that have the greatest overall impact on better health of the population, better health care, and lower costs.

Further, while I appreciate Medicare using their existing authorities to acknowledge and better capture the work that family physicians do every day, the option to bill for a service is of no benefit to us if barriers prevent patients from seeking out care. One such barrier is the existing 20 percent coinsurance requirement for most Part B services, including care management.

In 2015, Medicare began paying physicians for delivering non-face-to-face chronic care management (CCM) through separate codes. In 2025, CMS built upon this with the implementation of the APCM code bundles. Being able to bill for care management services has been an overall positive experience for my practice and many others. However, cost-sharing requirements continue to limit uptake by patients who would truly benefit from these services. A 2022 study found that MPFS billing codes for preventive medicine and care management services are being underutilized even though primary care physicians were providing code-appropriate services to many patients. The median use of the preventive and care coordination billing codes was 2.3 percent among eligible patients.[vii]

I've had patients opt out of receiving these services simply because the $15 or so a month they faced in cost-sharing was not financially feasible. In almost every case these were the very patients that would most benefit from CCM. This rings true for many of the other new codes Medicare has implemented, including G2211 and APCM. Patients are not used to paying for these services and, understandably, are resistant to doing so. Low utilization of these codes all but nullifies the efforts by Medicare to more meaningfully invest in primary care. If we want to incentivize usage of these high-value services, we must waive patient cost-sharing.

In many ways, CCM is a preventive service in that it reduces emergency department and other outpatient visits. Removing cost-sharing for CCM and other primary care services increases access to these services without increasing overall health care spending.[viii] The available evidence indicates that reducing or removing cost barriers to primary care increases utilization of preventive and other recommended primary care services, which improves both individual beneficiary and population health.

Therefore, the AAFP supports the *Chronic Care Management Improvement Act* (H.R. 8261), which would waive patient cost-sharing for the CCM codes under traditional Medicare. We urge Congress to pass this and other legislation to remove cost-sharing barriers for other care management services.

Supporting the Transition to Value-Based Primary Care Payment

APMs, when well-designed and implemented to meaningfully support primary care, provide practices with predictable, stable revenue streams that afford them the funding and flexibility needed to build teams and implement technology and infrastructure to deliver high-quality, patient-centered care – without the administrative complexity of FFS.

Value-based payment (VBP) arrangements, such as population-based payments (PBPs) or accountable care organizations (ACOs), better support and encourage physicians to deliver a more comprehensive set of services, such as care coordination and addressing HRSN, through prospective payment and flexibility. These types of arrangements invest in the longitudinal, continuous relationships primary care physicians have with their patients in ways that FFS has not historically and enable practices to tailor their care to better support patients with chronic conditions while improving related health outcomes. For example, practices might host monthly diabetes group visits to improve A1C. The frequent touches and support from these group visits can lead to better health outcomes for patients with type 2 diabetes and help the practice meet quality measure requirements.

Congress tried to provide an on-ramp for more practices to participate in APMs with the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) and implementation of MIPS, which was intended to provide clinicians with experience being measured on their performance. Unfortunately, continuous cuts to Medicare FFS payments have inhibited most practices from making the necessary investments that would allow them to successfully move into APMs. Further, the current design of MIPS, which focuses on individual clinician performance using largely process rather than outcomes measures, does not appear to be driving care improvements as much as it is adding administrative complexities that detract from patient care while unfairly penalizing small and rural practices.

I don't believe the current design of MIPS can or will serve as a meaningful transition to APMs as it does not change payment. Alternative payment is a foundational element of value-based payment models. Given that FFS payment of discrete services is inherently incompatible with the comprehensive,

continuous, relationship-based nature of primary care, MIPS or any other pay-for-performance program built upon FFS is limited in its utility to serve as a true mechanism to transition PCPs away from FFS. Instead, programs intended to "transition" primary care practices out of FFS are largely compliance programs that increase burden by forcing physicians to report on measures that are not relevant to patient care and outcomes and detract from time that could be spent with patients.

For these reasons, I strongly encourage Congress to consider a new program in conjunction with efforts to address budget neutrality constraints, in lieu of merely reforming MIPS. However, absent a viable alternative, there are policy changes Congress could implement to alleviate the administrative costs of reporting to the program, ensure it drives meaningful quality improvement, and assist physician practices in building the necessary competencies to transition into APMs. Specific recommendations to improve MIPS and the Quality Payment Program include:

- Granting CMS the authority to provide credit across multiple performance categories;
- Allowing practices to attest to using certified electronic health record technology in place of reporting on Promoting Interoperability measures;
- Providing CMS with the authority to modify the qualifying participant threshold through rulemaking to ensure it is attainable, and physician practices can receive the statutory benefits associated with advanced APM participation;
- Providing technical assistance, shared learning collaboratives, and data infrastructure to support all primary care practices to transition to APMs; and
- Funding technical assistance programs to support overall adoption of APMs by all practices in all settings.

Further congressional action is also needed to ensure federal policies provide appropriate support and incentives to physician practices moving into APMs. I appreciate that Congress passed legislation earlier this year to extend the advanced APM (AAPM) incentive payment through performance year 2026, albeit at a lower amount than originally authorized.

These payments have served as an important tool for attracting physicians to participate in AAPMs, which require significant upfront (and often ongoing) investments in new staff, technology, and other practice improvements. Primary care practices have also used the AAPM bonus payments to offset the cost of investing in care delivery transformation that drives success in these models by improving patient outcomes and lowering spending. Expiration of the AAPM incentive payment could institute an additional barrier to continued AAPM participation for physician practices and further impede family physicians' ability to transition value-based payment models.

However, primary care physicians still face significant barriers to entering and sustaining participation in VBP arrangements. Practices must comply with an ever-increasing number of federal and state regulations, negotiate contracts with multiple payers, acquire and effectively aggregate and analyze data to track patient utilization, treatment adherence, and identify outstanding needs – all while doing our primary job of taking care of patients. This creates an immediate and high barrier to entry, particularly for independent practices that don't have the upfront capital or resources.

To address this problem, Congress and CMS must work together to provide all family physicians with access to prospective, predictable, and mostly importantly *permanent* population-based payments. Such PBPs have demonstrated success in better supporting practices

and their delivery of patient-centered primary care. Unfortunately, the current statutory framework for model evaluation and expansion criteria has prevented CMMI from making important model improvements or continuing to test models that do not show significant net savings within a short model test period, ultimately causing more complexity and financial instability for participating physician practices.

Further, all CMMI primary care model evaluations have been done at the national level, which may be masking regional successes. This nearly-impossible-by-design threshold for scaling innovations is significantly hindering the transition to VBP, both in Medicare and across other payers. Physicians and practices are understandably unwilling (or, in many cases, unable given geographic restrictions) to make time and resource investments to join something that doesn't have a clear future and may ultimately disappear.

A variety of Center for Medicare and Medicaid Innovation (CMMI) models have utilized PBPs such as a per-member-per-month (PMPM) payment in ways that have helped participants provide more comprehensive, patient-centered primary care. For example, Comprehensive Primary Care Plus (CPC+) offered practices a non-visit-based care management fee payment which allowed practices to invest in staffing, care management workflows, and behavioral health integration. It also provided practices with a prospective primary care payment that reflected a percent of their expected FFS E/M claims payment. Participating practices reported they used the model's prospective payments to invest in care delivery transformation that would not have been possible if FFS was their only source of revenue. Some of these transformations included:

- Providing patients with after-hours access to a physician or other clinical staff member who has real-time access to the practice's EHR;
- Using designated care managers, typically on-site staff who are nurses or medical assistants, to deliver longitudinal care management services; and
- Co-location of a pharmacist at the practice site to support comprehensive medication management.

To be clear, the primary difference that afforded practices the opportunity to make these investments is that the payment was *prospective*; while they are possible to make in FFS, the retrospective payment makes it much more challenging for practices to do so.

More recent models, like Primary Care AHEAD, Primary Care First and Making Care Primary (PCF and MCP, both of which were terminated early in 2025), also provided primary care practices with a PBP that afforded them greater flexibility to tailor the delivery of patient care. The ongoing Primary Care AHEAD, which is part of the broader States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, provides participants with a prospective care management fee paid quarterly, ranging from $15 – 21, and adjusted based on both beneficiary risk and clinician quality performance.

Although the model was cut short, MCP met practices where they were with their level of VBP sophistication by offering both a risk-adjusted, tiered, prospective care management fee (inclusive of services such as chronic care management, behavioral health integration, and principal illness navigation) and a prospective primary care payment (inclusive of services like office visits, advance care planning, and depression screening).

We have been testing APMs for decades at this point, with results consistently indicating that there are certain innovations that work. For these elements, physicians and patients don't need more tests. They need stability and permanent options. I urge this Subcommittee and your colleagues in Congress to expand the availability of permanent, nationwide prospective population-based payment options for primary care.

In closing, thank you again for the opportunity to provide this testimony. On behalf of the AAFP and as a family physician, I look forward to working with the Subcommittee to advance policies that invest in high-quality primary care, improve patients' outcomes and experiences, and better support family physicians by more appropriately paying for the work we do. We all have the same goal: to improve the lives of the people we serve.

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