Primary Care Payment Reform

Background

Medicare's longstanding underinvestment in primary care, combined with its continued reliance on fee-for-service payment, has contributed to many of the challenges facing the U.S. health care system. Medicare payment policy therefore represents one of the most important opportunities to strengthen primary care and create a more sustainable health care system. In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which was intended to move physician payment away from traditional fee-for-service and toward value-based care. More than a decade later, that transition remains incomplete. Family physicians continue to practice under a Medicare Physician Fee Schedule (MPFS) with longstanding structural challenges that contribute to payment instability and make it difficult for practices to invest in the infrastructure needed to meaningfully transition to value-based care.

The Problem

- The United States invests just three to five cents of every health care dollar in primary care, with Medicare investing less than other payers. Because private insurers often base their payment rates on Medicare, this underinvestment has implications across the health care system.
- The Medicare Physician Fee Schedule (MPFS) is the only major Medicare payment system that does not include a permanent inflationary update. As a result, when adjusted for inflation, physician payment declined 33% between 2001 and 2025.
- Under the proposed CY 2027 MPFS, physicians would face an additional 1.19% to 1.68% reduction, depending on participation in an Advanced Alternative Payment Model. This reflects the lack of an inflationary update and the expiration of a temporary congressional payment increase.
- Budget neutrality requirements, which have remained largely unchanged since the 1990s, require CMS to offset increases in payment for new or existing services with reductions elsewhere in the fee schedule. This makes it increasingly difficult to invest in new services without creating cuts elsewhere.
- Without a more sustainable approach to physician payment, continued instability has implications for patient access to primary care, practice sustainability, and ongoing consolidation across the health care system

Legislative Fixes

The following bills represent proposed legislative fixes aimed at modernizing this outdated payment system. Each has been introduced in Congress but has not yet passed; the summaries below reflect each bill as introduced, and their status may change as they move through committee.

H.R. 9693 Patients First Act of 2026

Sponsors: Reps. John Joyce (R-PA), Greg Murphy (R-NC), and Kim Schrier (D-WA)

This bill stabilizes payment with an annual inflationary update tied to the Medicare Economic Index, establishes a 5-year primary care pilot with prospective per-member-per-month payments for independent practices, replaces MIPS with a physician-led quality measurement system, reforms outdated budget-neutrality requirements, and freezes the Advanced Alternative Payment Model participation threshold for three years

S. 5269 Pay PCPs Act of 2026

Sponsors: Sen. Sheldon Whitehouse (D-RI) and Sen. Bill Cassidy (R-LA)

Authorizes HHS to establish a voluntary hybrid Medicare primary care payment model combining prospective per-member-per-month (PMPM) payments with fee-for-service. The PMPM payment could represent roughly 40 to 70% of expected annual primary care charges and would support care coordination, team-based care, and other traditionally unpaid work, while preventive services and vaccinations remain separately payable. The bill provides $10 billion for FY2027–FY2031, exempt from Medicare Physician Fee Schedule budget neutrality, allows HHS to reduce beneficiary cost sharing by 50% for primary care services, and establishes a CMS advisory committee to examine how relative value units are calculated.

H.R. 8163 Provider Reimbursement Stability Act

Sponsors: Rep. Gregory Murphy (R-NC)

This bill raises the Medicare Physician Fee Schedule's budget-neutrality threshold from $20 million to $54.3 million and indexes it to the Medicare Economic Index every five years, corrects budget neutrality for actual code utilization, updates practice-expense RVU cost data at least every five years, and caps year-to-year conversion factor swings at 2.5%.

H.R. 8622 Medicare Physician Data-driven Performance Payment System Act

Sponsor: Rep. Mariannette Miller-Meeks (R-IA)

Proposes reforms to the Merit-based Incentive Payment System (MIPS), the quality-reporting framework created under MACRA. Like H.R. 8163, this is a targeted bill addressing a single structural problem, MIPS's quality measures, rather than a comprehensive overhaul.

H.R. 1254 Rural Obstetrics Readiness Act

Sponsor: Rep. Robin Kelly (D-IL)

Strengthens emergency obstetric care in rural and maternity care shortage areas through HRSA grants for workforce training, equipment, and telehealth consultation. The bill also supports clinicians in rural facilities without dedicated labor and delivery units who may still need to provide emergency care to pregnant and postpartum patients. This comes as more than one-third of U.S. counties are maternity care deserts and rural communities continue to lose labor and delivery services, with at least 96 units closing across 35 states between January 2024 and May 2026.

Why It Matters for Family Medicine

Together, these bills represent an important bipartisan effort to address the structural underinvestment in primary care within the Medicare Physician Fee Schedule. The Patients First Act offers a comprehensive approach to payment reform, while several other impactful bills are moving alongside it, addressing specific components of the same underlying challenges. The Rural Obstetrics Readiness Act complements these efforts by recognizing the critical role family physicians play in maintaining access to maternity care in rural communities, particularly where they may be the only available source of obstetric care.