national partnership for women & families

Ensuring Primary Care for All

The Urgent Case for RUC Reform

MAY 2025

Most people believe the United States health care system is in crisis or has major problems.[1] Building a health care system that truly works well for everyone requires a strong, people-centered primary care[1] foundation to serve as the main point of contact and ongoing support for people across their lifetime. This approach is supported by evidence showing better health outcomes and lower long-term costs, and aligns with surveys consistently showing people want a trusted primary care provider (PCP).[2] More than four of every five people prioritize having a regular primary care clinician they can trust.[3]

Unfortunately, the way our health care system is designed makes it nearly impossible for the supply of primary care providers to effectively meet its demand. Many counties in the United States already qualify as primary care shortage areas and the numbers are increasing.[4] Several factors contribute to this market failure, but a key issue is that the current payment system undervalues primary care. Primary care providers are paid less for their work compared to specialists, making it harder to cover practice expenses and invest in the infrastructure needed to deliver comprehensive, person-centered care.

At the root of this disconnect lies a relatively obscure, far from transparent entity called the Relative Value Scale Update Committee, better known as the RUC. The RUC, in effect, lets doctors decide how much to pay themselves, and unfortunately, primary care doctors are far outnumbered by specialists on this powerful committee. **This is why advocates who want to ensure that everyone can build a long-term relationship with a primary care clinician they can trust, who will take the time needed to understand their patients' specific ongoing health needs, and help coordinate that care, should pay attention to RUC reform.**

[1] High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.[5]

What Is the RUC and Why Should You Care?

The RUC is a 32-member panel of majority specialty physicians, convened by the American Medical Association (AMA), that makes recommendations to the Centers for Medicare & Medicaid Services (CMS) about how much traditional Medicare should pay physicians for health care services.

What are RVUs?

The RUC assigns relative value units (RVUs) to physician services based on the resources needed to provide them. The resources take into account three factors: the physician's work (including time, skill, and effort), practice expenses, and malpractice costs. Each RVU component is adjusted for geographic location then converted to a dollar amount using the annual conversion factor set by the annual Medicare Physician Fee Schedule (MPFS).[6] Physicians claim reimbursement for their services using medical, surgical, and diagnostic codes, known as CPT codes, each corresponding to the RVUs assigned by the RUC.

Even though the RUC's jurisdiction technically is limited to an *advisory role in traditional Medicare*, its actual power far exceeds this. First, CMS — the nation's single largest payer of health care services — accepts over 90 percent of its payment rate recommendations.[7] Additionally, the RUC's influence is not limited to traditional Medicare. Many state Medicaid programs, private insurers, and other payers use Medicare rates and CPT codes, which are owned and copyrighted by the AMA, as a benchmark to set their own physician payment. As a result, the AMA receives a substantial source of revenue from charging royalties to use CPT codes, accounting for over 50 percent of their profits since 2019.[8] The RUC's recommendations have a ripple effect — any distortions and undervaluations in Medicare payment are ingrained into the broader health care system. These undervaluations contribute to systemic payment inequities that undermine access to comprehensive, person-centered care.

The RUC Undermines Primary Care Access and Quality

The RUC's structure and decision-making processes is an extremely distorted payment system that devalues primary care and behavioral health services, fueling provider shortages that have a direct impact on people's timely access to the care they need. The RUC overvalues episodic care and procedures in an increasingly fragmented, difficult to navigate sick-care environment. This comes at the expense of relationship-based, whole-person preventive and primary care designed to keep people healthy.

Primary Care Services Often Undervalued[9]

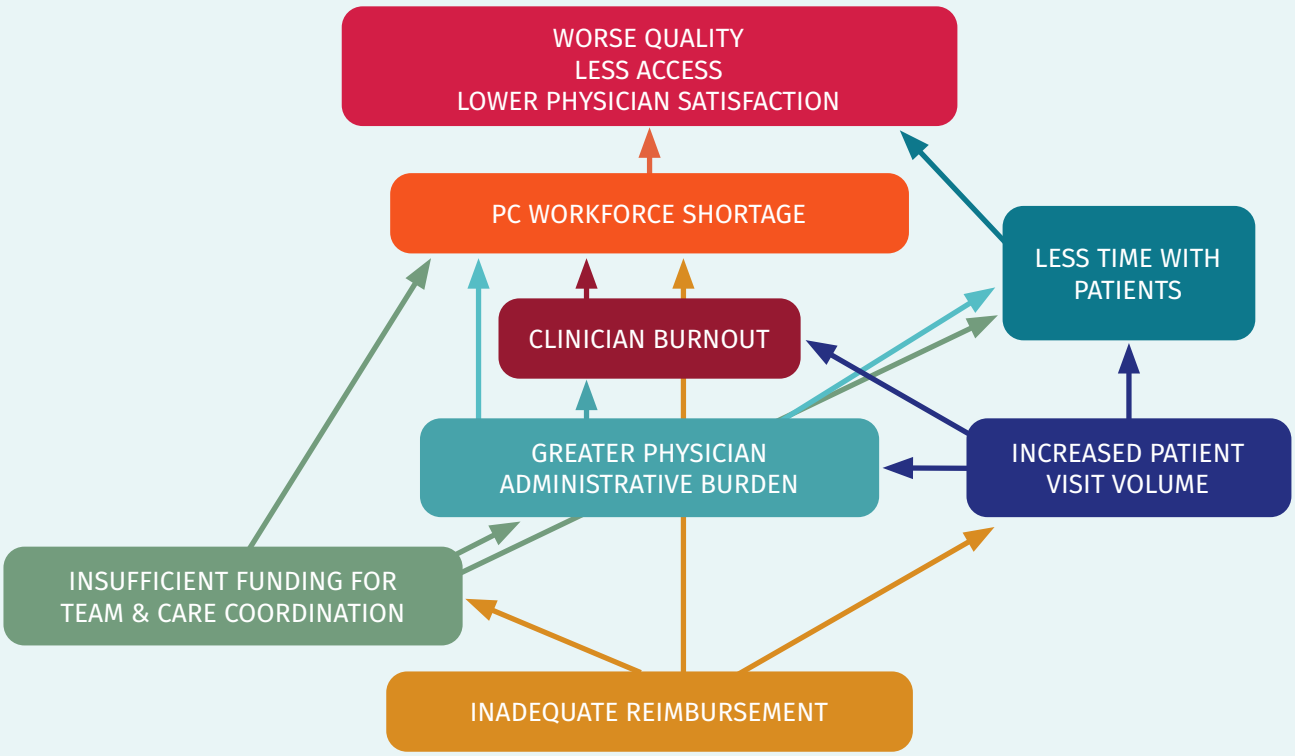
Core In-Office Services	Behind-the-Scenes Work
Annual Wellness Visits	Prior Authorizations
Contraceptive Counseling	Care Coordination and referrals
Flu shots and other immunizations	Responding to patient emails and messages
Preventive Screenings	Reviewing lab results
Documenting family health history	Preparing care plans and quality reporting
The RUC's recommendations have historically inflated payments for procedural specialty services while undervaluing the nonprocedural, person-centered, time intensive care fundamental to primary care and behavioral health.	

These payment disparities directly curtail people's access to primary care and can compromise the quality of care they are able to get by:

- **Limiting time clinicians have with their patients:** Underpayment for primary care forces providers to increase the number of people they serve per day to sustain sufficient volume to remain financially viable. Fitting in more patients per day requires shorter visits, leaving less time to address prevention, answer questions, jointly develop care plans, coordinate care, and develop trust and understanding of the patient's holistic needs in general. This is especially important for people with chronic or complex conditions.
- **Restricting team-based, person-centered care**: The current fee schedule does not adequately value or account for the full range of services, activities, and disciplines needed to provide high-quality primary care. Studies show that at least 20 percent of *primary care activities* — including nonprocedural services like care coordination, interdisciplinary collaboration, and patient portal communications — are not covered under the MPFS.[10] *Non-physician team members*, such as clinical pharmacists, behavioral health specialists, and care managers, play vital roles in patient care but often perform services that are not adequately reimbursed or at all under current payment structures.[11] These team members are especially important in rural communities that often face workforce shortages. This makes it difficult for practices to invest in team-based care models that are critical for managing chronic conditions and addressing whole-person health needs.

- **Driving primary care workforce shortages:** Persistent underpayment in Medicare has made it difficult for clinicians to sustain careers in primary care. Practices are often not paid enough to cover the necessary expenses, which is discouraging for new graduates burdened with student debt.[12] The clinicians who decide to go into primary care face rising administrative demands and worsening burnout. This pushes many towards higher-paying specialties, which inevitably reduces patient access to primary care.
- **Limiting access to prevention and effective chronic condition management:** The primary care shortage limits patients' access to preventive services, exacerbating underlying health outcomes. Patients without a regular PCP are more likely to delay care until complications arise or miss early warning signs, leading to greater reliance on costly emergency or acute care services.[13] The downstream effect creates higher health care spending and worse outcomes for patients and communities.
- **Incentivizing overuse of expensive and unnecessary services:** In addition to resulting in increased use of more expensive services that could have been prevented, this payment structure directly incentivizes using more specialty procedures that might not even improve outcomes, increasing the costs for patients and payers, and potentially risking patient safety.

The Profound Consequences of Neglecting Primary Care



The RUC Is Deeply Flawed

Systems are perfectly designed for the results they produce. The RUC is flawed in a number of ways that compromise its ability to fairly set payment structures that actually pay for the high-quality care that people need and prioritize, especially, but not exclusively, the more cognitive and relationship-based aspects of health care. We've identified specific flaws that must be remedied.

- **Specialty-dominated composition and conflict of interest:** The RUC is primarily composed of representatives from procedural specialties, whose financial interests are directly tied to the outcomes of its recommendations.[14] This affects how services are valued and which are prioritized. The RUC has prioritized increasing payment rates and adding more billable codes over reducing payments for services shown to be overvalued, contributing to higher Medicare spending. The broader valuation process also lacks meaningful engagement from patients, advocates, and other primary care experts who could help ensure payment reflects what patients need from the health care system.
- **Flawed data collection:** A key part of the RUC's process involves administering surveys to practicing physicians to estimate the time and intensity required to deliver various services. These surveys are distributed to a random sample of physicians within the relevant specialty that performs the services being valued. These surveys have been shown to consistently overestimate the time and effort required for procedures, leading to inflated reimbursements for procedural services.[15] The RUC valuation process heavily relies on this self-reported time data, which lacks third-party verification. Its valuation framework focuses narrowly on time, skill, and effort and does not accurately reflect the care coordination and management complexity involved in primary care. The RUC also does not take into account the patient outcomes tied to the services, contributing to the lack of accountability.
- **Lack of transparency:** Access to RUC meetings is restricted, and documentation of deliberations is not easily available. This makes it difficult for CMS, Congress, or advocates to evaluate how recommendations are developed or hold members accountable for potential biases. The absence of clear oversight mechanisms allows the RUC to operate without checks and balances, reinforcing a process that prioritizes internal interests over broader system needs.

Payment Reforms and Barriers to Uptake

CMS has made some efforts to improve reimbursement for primary care, but these reforms have had limited success.[16]

- **Annual wellness visits (AWVs),** introduced in 2011, to implement higher reimbursement for preventive services than previous codes.[17]
- **Transitional care management and chronic care management codes** followed in 2013 and 2015, to compensate for care activities that occur outside of traditional office visits.[18]
- **Increased RVUs for Evaluation & Management codes,** implemented in 2021, focus on addressing immediate health concerns rather than maintaining overall health long term.[19]
- **G2211 add-on code,** introduced in 2024, to support longitudinal, comprehensive primary care.
- **Advanced Primary Care Management (ACPM) codes,** implemented in 2025, combine existing care management codes and streamline billing and documentation requirements. This is an effort to make primary care more accessible, coordinated, and person-centered, **but it is too early to assess its full impact**.[20]

Adoption of these codes has been slow due to low payment rates that do not cover the cost of implementation. Additional barriers include complex requirements for beneficiary consent and time tracking, administrative burdens relating to staff training and compliance, and concerns over patient cost-sharing. In general, these codes have had a modest effect in closing the primary care payment disparity.

Additionally, **CMS must maintain budget neutrality, meaning if the RUC recommends rate increases for one service,** it must cut payment for other services.[21] This creates a zero-sum game, where pay increases to primary care must be offset with cuts to other specialties. External pressures from specialty group influence how these payments are distributed.

Bipartisan Efforts to Bolster Primary Care

In 2024, Congress introduced the bipartisan Pay PCPs Act, which would establish the option for primary care providers in Medicare to receive reliable and upfront population-based payments for under-reimbursed activities, while maintaining some traditional FFS payments for certain services.[22] This payment approach would better support the full scope of primary care and reduce overreliance on fee-for-service. The legislation would also reduce beneficiary cost-sharing for select primary care services and **establish a new technical advisory committee — separate from the RUC** — within CMS to advise the agency on new methods to more accurately determine physician rates.

Opportunities for RUC Reform

In his new role as Secretary of Health and Human Services, Robert F. Kennedy Jr. has signaled interest in overhauling Medicare's physician payment system to better support primary care and preventive services. This follows a year of preliminary action from Congress to change how Medicare pays primary care providers.[23] As policymakers consider how to build a stronger foundation for primary care, reforming the RUC is essential to ensuring that payment supports the high-quality, person-centered care patients value most. To support a more person-centered, equitable payment system, advocates are encouraging for the following reforms:

More balanced and transparent valuation process

- Congress should require the **inclusion of patient advocates**, public health experts, and independent policy researchers into the valuation process, and there must be greater representation of primary care and behavioral health providers.
- The RUC's reliance on physician surveys should be replaced with objective, **empirical data collection** to set more accurate reimbursement rates.[24]

Stronger support for person-centered care

- Congress must remedy the historic and ongoing undervaluing of primary care and behavioral health services. Congress should give CMS authority to **rebalance the distribution of resources** within Medicare by focusing on what patients want and need: relationships, addressing holistic needs, and improving health outcomes.

Greater infrastructure investment in primary care

- Valuations of primary care services should account for **startup and transformation costs**, including electronic health record (EHR) upgrades, care coordination tools, and social needs interventions.

Conclusion

The RUC's outsized influence over Medicare physician payments has contributed to systemic inequities in how primary care is valued and funded. Its confusing and opaque processes are intentionally designed to create barriers to engagement and limit input from patients, advocates, and other non-specialty-driven stakeholders. While some reforms have been made, substantive changes will require structural shifts toward transparency, fairness, and evidence-based valuation methods. Advocates must use this moment to push for policies that open valuation processes to broader perspectives and ensure primary care providers are adequately compensated for the services that matter most to patients' health and well-being.

References

[1] Brenan, M. (2024, December 6). View of U.S. healthcare quality declines to 24-year low. Gallup. Retrieved 29 April 2025, from https://news.gallup.com/poll/654044/view-healthcare-quality-declines-year-low.aspx

[2] Stange, K. C., Miller, W. L., & Etz, R. S. (2023, April 25). The role of primary care in improving population health. The Milbank Quarterly, 101(S1), 795–840. Retrieved 29 April 2025, from https://doi.org/10.1111/1468-0009.12638

[3] United States of Care. (2025). People demand better primary care: Recent research and insights from the people's perspective. Retrieved 29 April 2025, from https://unitedstatesofcare.org/wp-content/uploads/2025/03/US_Primary_Care.pdf

[4] Kaiser Family Foundation. (n.d.). Primary care health professional shortage areas (HPSAs). Retrieved 29 April 2025, from https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/

[5] National Academies of Sciences, Engineering, and Medicine. (2021). Implementing high-quality primary care: Rebuilding the foundation of health care. Retrieved 29 April 2025, from https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health

[6] AAPC. (n.d.). What are relative value units (RVUs)? Retrieved 29 April 2025, from https://www.aapc.com/resources/what-are-relative-value-units-rvus

[7] American Medical Association. (2024). 2025 Medicare physician payment schedule (PFS) and quality payment program (QPP) final rule summary. Retrieved 29 April 2025, from https://www.ama-assn.org/system/files/ama-2025-mpfs-summary.pdf

[8] Suozzo, A., Glassford, A., & Roberts, B. (2025, April 23). American Medical Association - Nonprofit Explorer (J. Frankl, K. Schwencke, M. Tigas, & S. Wei, Eds.). ProPublica. Retrieved 29 April 2025, from https://projects.propublica.org/nonprofits/organizations/360727175

[8] Jabbarpour, Y., Jetty, A., Byun, H. & Siddiqi, A. (2025). The cost of neglect: How chronic underinvestment in primary care is failing U.S. patients. Milbank Memorial Fund. Retrieved 29 April 2025, from https://www.milbank.org/wp-content/uploads/2025/02/Milbank-Scorecard-2025-ACCESS-v07.pdf

[9] Chen, M. A., Hollenberg, J. P., Michelen, W., Peterson, J. C. & Casalino, L. P. (2010, September 2). Patient care outside of office visits: A primary care physician time study. Journal of General Internal Medicine, 26(1), 58–63. Retrieved 29 April 2025, from https://doi.org/10.1007/s11606-010-1494-7

[10] National Academies of Sciences, Engineering, and Medicine. (n.d.). Improving primary care valuation decisions for the physician fee schedule by the Center for Medicare. Retrieved 29 April 2025, from https://www.nationalacademies.org/our-work/improving-primary-care-valuation-decisions-for-the-physician-fee-schedule-by-the-center-for-medicare

[11] Hoffer, E. P. (2024, August). Primary care in the United States: Past, present and future. The American Journal of Medicine, 137(8), 702–705. Retrieved 29 April 2025, from https://doi.org/10.1016/j.amjmed.2024.03.012

[12] See note 6.

[13] American Medical Association. (2024). AMA/Specialty society RVS update committee. Retrieved 29 April 2025, from https://www.ama-assn.org/system/files/ruc-update-booklet.pdf

[14] Sinsky, C. A. & Dugdale, D. C. (2013, October 14). Medicare payment for cognitive vs. procedural care: Minding the gap. JAMA Internal Medicine, 173(18), 1733–1737. Retrieved 29 April 2025, from https://www.doi.org/10.1001/jamainternmed.2013.9257

[15] See note 10

[16] Ganguli, I., Souza, J., McWilliams, J. M. & Mehrotra, A. (2018, February). Practices caring for underserved less likely to adopt Medicare's Annual Wellness Visit. Health Affairs, 37(2), 283–291. Retrieved 29 April 2025, from https://doi.org/10.1377/hlthaff.2017.1130

[17] Moore, K. (2015). Chronic Care Management and Other New CPT Codes. Family Practice Management, 22(1), 7–12. https://www.aafp.org/pubs/fpm/issues/2015/0100/p7.html

[18] Centers for Medicare & Medicaid Services. (2020, December 1). Final policy, payment, and quality provisions changes to the Medicare Physician Fee Schedule for calendar year 2021. Retrieved 29 April 2025, from https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1

[19] Centers for Medicare & Medicaid Services. (2024, November 1). Calendar year (CY) 2025 Medicare Physician Fee Schedule final rule. Retrieved 29 April 2025, from https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule

[20] Cottrill, A., Cubanski, J. & Neuman, T. (2025, March 24). What to know about how Medicare pays physicians. Kaiser Family Foundation. Retrieved 29 April 2025, from https://www.kff.org/medicare/issue-brief/what-to-know-about-how-medicare-pays-physicians/

[21] Sheldon Whitehouse. (2024, May 15). Whitehouse and Cassidy introduce legislation, release RFI on primary care provider payment reform. Retrieved 29 April 2025, from https://www.whitehouse.senate.gov/news/release/whitehouse-and-cassidy-introduce-legislation-release-rfi-on-primary-care-provider-payment-reform/

[22] Pay PCPs Act of 2024. Retrieved 29 April 2025, from https://www.whitehouse.senate.gov/wp-content/uploads/2024/05/KEL24351.pdf

[23] Zuckerman, S., Upadhyay, D., Merrell, K., Lewis, R., Berenson, R. & Mitchell, S. (2016, December). Collecting empirical physician time data: Piloting an approach for validating work relative value units. Urban Institute. Retrieved March 28, 2025, from https://www.urban.org/sites/default/files/publication/87771/2001123-collecting-empirical-physician-time-data-piloting-approach-for-validating-work-relative-value-units_0.pdf

Acknowledgements
This report was authored by:

- Kiera Peoples, Health Policy Analyst, NPWF
- Sarah Coombs, Director for Health System Transformation, NPWF
- Sinsi Hernández-Cancio, Senior Fellow for Health Equity

The following people contributed to this report:

- *Erin Mackay, Managing Director, NPW*
- *Jorge Morales, Editor*
- *Evan Potler, Designer, Factor3 Digital*

About the National Partnership
The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to achieving equity for all women. We work to create the conditions that will improve the lives of women and their families by focusing on achieving workplace and economic equity, and advancing health justice by ensuring access to high-quality, affordable, and equitable care, especially for reproductive and maternal health. We are committed to combatting white supremacy and promoting racial equity. We understand that this requires us to abandon race-neutral approaches and center the intersectional experiences of women of color to achieve our mission.

Support for this report was provided by Arnold Ventures.

1725 I Street NW, Suite 950
Washington DC 20006
nationalpartnership.org