

Documents for the Record

Subcommittee on Health Hearing “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity.” September 15, 2025

Majority:

1. September 15, 2026, statement for the record submitted by the American Clinical Neurophysiology Society in support of the Patients First Act (H.R. 9693).
2. September 15, 2026, letter to the Honorable H. Morgan Griffith and the Honorable Diana DeGette from the American Pharmacists Association in support of the Ensuring Community Access to Pharmacist Services Act (H.R. 3164).
3. September 15, 2026, letter to the Honorable H. Morgan Griffith and the Honorable Diana DeGette from the American Society of Health-System Pharmacists in support of the Ensuring Community Access to Pharmacists Act (H.R. 3164).
4. September 15, 2026, statement for the record submitted by the National Community Pharmacists Association in support of the Ensuring Community Access to Pharmacist Services Act (H.R. 3164).
5. September 15, 2026, letter to the Honorable John Joyce, MD; the Honorable Greg Murphy, MD; and the Honorable Kim Schrier, MD, from the American Academy of Sleep Medicine (AASM) in support of the Patients First Act (H.R. 9693).
6. September 15, 2026, statement for the record submitted by the American Nurses Association (ANA) regarding the Promoting Access to Diabetic Shoes Act (H.R. 1616) and the Patients First Act of 2026 (H.R. 9693).
7. September 15, 2026, statement for the record submitted by the American College of Cardiology regarding the Access to Claims Data Act (H.R. 4331), the Provider Reimbursement Stability Act (H.R. 8163), the Rural Obstetrics Readiness Act (H.R. 1254), the Radiology Outpatient Ordering Transmission (ROOT) Act (H.R. 5737), and the Patients First Act (H.R. 9693).
8. September 15, 2026, letter to the Honorable Brett Guthrie, the Honorable H. Morgan Griffith, the Honorable Frank Pallone, and the Honorable Diana DeGette from March of Dimes in support of the Rural Obstetrics Readiness Act (H.R. 1254).
9. September 15, 2026, letter to the Honorable Chairman Brett Guthrie and the Honorable H. Morgan Griffith from Catherine Heege in support of the Alzheimer’s Screening and Prevention (ASAP) Act (H.R. 6130).
10. September 15, 2026, statement for the record submitted by the American Society of Anesthesiologists (ASA) regarding the Patients First Act (H.R. 9693) and the Provider Reimbursement Stability Act of 2026 (H.R. 8163).
11. September 15, 2026, statement for the record submitted by Kidney Care Partners (KCP) in support of the Kidney Care Access Protection Act (H.R. 6214).

12. September 15, 2026, statement for the record submitted by the Alliance for Home Dialysis regarding the KIDNEY Remote Monitoring Act (H.R. 8319) and the Kidney Care Access Protection Act (H.R. 6214).
13. September 15, 2026, statement for the record submitted by the Infectious Diseases Society of America regarding the Patients First Act (H.R. 9693).
14. September 15, 2026, statement for the record submitted by the American College of Lifestyle Medicine (ACLM) regarding the Patients First Act (H.R. 9693) and the Provider Reimbursement Stability Act of 2026 (H.R. 8163).
15. September 15, 2026, statement for the record submitted by the American College of Radiology in support of the Patients First Act (H.R. 9693).
16. September 15, 2026, statement submitted by the American Hospital Association regarding the legislation included in the Subcommittee on Health legislative hearing titled “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity.”
17. September 15, 2026, statement for the record submitted by the Primary Care Collaborative regarding the Patients First Act of 2026 (H.R. 9693).
18. September 15, 2026, statement for the record submitted by CVS Health in support of the Ensuring Community Access to Pharmacist Services Act (H.R. 3164).
19. September 15, 2026, statement for the record submitted by the Future of Pharmacy Care Coalition (FPCC) in support of H.R. 3164.
20. September 15, 2026, letter to the Honorable Brett Guthrie, the Honorable H. Morgan Griffith, the Honorable Frank Pallone, and the Honorable Dianna DeGette from the American Association of Nurse Practitioners in support of the Promoting Access to Diabetic Shoes Act (H.R. 1616) and the Patients First Act of 2026 (H.R. 9693).
21. September 15, 2026, statement for the record submitted by the Honorable H. Morgan Griffith on behalf of the Honorable Vern Buchanan in support of his bill, the ASAP Act (H.R. 6130).
22. September 15, 2026, letter to the Honorable Brett Guthrie, the Honorable Jason Smith, the Honorable Frank Pallone, and the Honorable Richard Neal from the Alliance for Patient Access (AfPA) in support of the Alzheimer’s Screening and Prevention (ASAP) Act (H.R. 6130).
23. September 15, 2026, statement for the record submitted by the Society of Thoracic Surgeons (STS) regarding the legislation included in the hearing titled “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity.”
24. September 15, 2026, statement for the record submitted by the American College of Gastroenterology regarding the Patients First Act (H.R. 9693).
25. September 15, 2026, statement for the record submitted by U.S. Renal Care regarding H.R. 6214.
26. September 15, 2026, letter to the Honorable Brett Guthrie, the Honorable Frank Pallone, Jr., the Honorable H. Morgan Griffith, and the Honorable Diana DeGette from the American Dental Association regarding the Dental and Optometric Care (DOC) Access Act (H.R. 1521).
27. September 15, 2026, statement for the record submitted by the National Infusion Center regarding H.R. 8163 and H.R. 9693.

28. September 15, 2026, statement for the record submitted by the American Podiatric Medical Association regarding H.R. 7905.
29. September 15, 2026, statement for the record submitted by the Heart Rhythm Advocates regarding the legislation included in the hearing titled “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity”
30. September 15, 2026, statement for the record submitted by American Alliance of Orthopedic Executives (AAOE).
31. September 15, 2026, statement for the record submitted by the Dermatologists Engaged for Responsible Medicine (DERM) in support of the Patients First Act of 2026.
32. September 15, 2026, statement for the record submitted by the Honorable Neal P. Dunn in support of H.R. 4299.
33. September 15, 2026, letter to the Honorable H. Morgan Griffith and the Honorable Diana DeGette regarding the Patients First Act of 2026, the Provider Reimbursement Stability Act, and the Medicare Physician Data-driven Performance Payment System Act of 2026.
34. September 15, 2026, statement for the record from the Honorable Jen Kiggans (submitted by Rep. Griffith).

Minority:

1. September 15, 2026, statement from Federation of American Hospitals.
2. September 15, 2026, statement from Renal Healthcare Association.
3. September 15, 2026, statement from the American Academy of Physician Associates.
4. September 15, 2026, statement from the Primary Care Collaborative.
5. September 15, 2026, statement from the Honorable Jim Costa.
6. September 15, 2026, statement from the Honorable Diana DeGette.
7. Letter from the Alliance for Patient Access.
8. September 15, 2026, statement from AHIP.
9. September 15, 2026, letter from various organizations in support of H.R. 1616 (submitted by Rep. Barragan).

Statement for the Record
Submitted by the American Clinical Neurophysiology Society
re: the House Energy & Commerce Committee Hearing on the Patients First Act
September 15, 2026

The American Clinical Neurophysiology Society (ACNS) appreciates the opportunity to submit this statement for the record for today's hearing in support of the Patients First Act (H.R. 9693), which is led by committee members Rep. John Joyce (R-PA) and Rep. Kim Schrier (D-WA). ACNS is supportive of this bipartisan legislation to address longstanding challenges within the Medicare physician fee schedule and to modernize the Medicare Access and CHIP Reauthorization Act (MACRA).

Founded in 1946, ACNS is a professional medical society representing more than 1,600 physicians, researchers, and allied health professionals dedicated to advancing excellence in clinical neurophysiology. Our members diagnose and treat patients with complex neurologic conditions using technologies such as electroencephalography (EEG), electromyography (EMG), nerve conduction studies, intraoperative monitoring, sleep studies, and related neurophysiologic techniques. Many of the patients served by ACNS members are Medicare beneficiaries, making a stable and sustainable Medicare physician payment system critically important to preserving patient access to specialized neurological care.

ACNS strongly supports the Patient's First Act's approach to physician payment reform and urges Congress to act this year to stabilize and improve the Medicare physician payment system. The current system is unsustainable for both patients and providers. Repeated payment reductions, combined with rising practice costs, inflationary pressures, and increasing administrative burden, are placing enormous strain on physician practices across the country. While hospitals and other providers receive regular payment updates tied to inflation, physicians continue to face stagnant reimbursement and annual uncertainty surrounding payment cuts. Furthermore, the conversion factor has changed very little in 30 years; in 1998, the conversion factor was \$36.6873 and in 2026, the conversion factor was \$33.4009 for the non-APM conversion factor.

The cumulative impact of chronic underpayment is increasingly threatening patient access to care. Physician practices are struggling to absorb escalating costs associated with staffing, technology, compliance, supplies, and facility operations. For many practices, these financial pressures are no longer manageable. As a result, physicians are being forced to reduce services, limit Medicare participation, delay investments in innovative care delivery, or close practices altogether.

At the same time, inadequate physician reimbursement is accelerating consolidation throughout the healthcare system. Independent physician practices are increasingly being acquired by hospitals and large health systems because physicians cannot remain financially viable under the current Medicare payment structure. This trend has significant implications for patients, including reduced competition, higher healthcare

costs, and fewer choices for care in local communities. Consolidation is particularly harmful in highly specialized fields such as clinical neurophysiology, where patients often rely on access to community-based specialists for timely diagnosis and treatment of complex neurological conditions.

ACNS believes Congress must address the structural flaws in MACRA that have contributed to this instability. While MACRA successfully repealed the Sustainable Growth Rate (SGR) formula and sought to incentivize value-based care, the law has failed to incentivize value-based care with far fewer physicians in advanced alternative payment models as envisioned by the authors of MACRA and exacerbated the downward pressure on physician reimbursement. The statutory budget neutrality requirements and the absence of an adequate inflationary update mechanism continue to create annual payment instability and uncertainty for physicians.

ACNS also emphasizes that physician payment reform is fundamentally about preserving patient access to care. Patients cannot benefit from innovations in healthcare delivery if there are insufficient physicians able to provide those services. Neurologic disorders are often chronic, progressive, and time-sensitive, requiring highly trained specialists and advanced diagnostic testing. Ensuring adequate reimbursement for these services is essential to maintaining healthcare access for Medicare beneficiaries.

We commend the Committee for considering the Patients First Act and for recognizing the urgent need for action. Physicians across specialties have faced years of instability and uncertainty under the current system, and patients are increasingly experiencing the downstream effects through workforce shortages, longer wait times, and reduced access to independent specialty care.

ACNS strongly encourages the Committee to pass the Patients First Act to enact meaningful physician payment reform this year, which will create long-term stability, support independent physician practices, advance value-based care, and protect patient access to high-quality specialty services.

Thank you for the opportunity to submit this statement for the record and for your leadership on this important issue.



September 15, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
2323 Rayburn House Office Building
Washington, DC 20515

Re: Statement for the Record: Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity

Dear Chairman Griffith and Ranking Member DeGette,

APhA appreciates the opportunity to submit this Statement for the Record on the House Energy and Commerce Subcommittee on Health's hearing on "Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity."

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists and pharmacy personnel in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

We were pleased to see the Committee include H.R. 3164, the Ensuring Community Access to Pharmacist Services Act (Reps. Smith and Schneider) / Main Street Pharmacy Access Act, on the agenda. We strongly support H.R. 3164 and urge its swift passage by the Committee.

H.R. 3164 is bipartisan, common-sense legislation supported by the majority of the Committee, over [50 organizations](#) representing patients, seniors, and rural Americans, over [100 organizations](#) representing our nation's pharmacists and their patients, [91 pharmacy deans](#) from U.S. colleges and schools of pharmacy, representing institutions across 37 states and Puerto Rico, and over [45 organizations](#) representing hospitals and health systems.

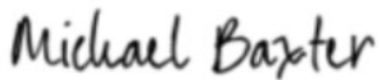
For millions of Americans, their local pharmacist is the health care professional they know best and see most often. With a community pharmacy located within five miles of nearly all Americans, pharmacists are uniquely positioned to deliver personalized care and provide a

vital connection to the broader health care system. Patients rely on their pharmacists not only for medications, but also for trusted advice, preventive services, chronic disease management, and guidance through complex health care decisions. As one of the most easily accessible health care clinicians, pharmacists play a vital role in ensuring patient access to health care and are an integral part of the health care team.

H.R. 3164 would ensure pharmacists can provide services to America's seniors, particularly by providing reimbursement through Medicare Part B for testing and treatment of common upper respiratory conditions to expand access to care that pharmacists are authorized by their states to provide, particularly in rural and underserved areas where other health care options may be limited; save taxpayer dollars; and reduce overall health care costs by keeping seniors out of expensive emergency rooms. Passing this bill would go a long way toward giving patients access to health care where they live, with local clinicians they know and trust.

We thank the Committee for its ongoing efforts to improve access to affordable, accessible health care by supporting H.R. 3164 and advancing this legislation to become law. If you have any questions or would like to speak with a pharmacist in your congressional district, please contact APhA Director of Congressional Affairs, Douglas Huynh, JD, at dhuynh@aphanet.org.

Sincerely,

A handwritten signature in dark ink that reads "Michael Baxter". The script is cursive and fluid, with the first name "Michael" and last name "Baxter" clearly legible.

Michael Baxter
Vice President, Government Affairs

cc: The Honorable Brett Guthrie, Chairman
The Honorable Frank Pallone, Ranking Member
The Honorable Diana Harshbarger
The Honorable Doris Matsui
The Honorable Buddy Carter
Members of the House Committee on Energy and Commerce



September 15, 2026

The Honorable Chairman Morgan Griffith
House Committee on Energy and Commerce
Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Ranking Member Diana DeGette
House Committee on Energy and Commerce
Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

Re: Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity.

Dear Representatives Griffith and DeGette:

Thank you for holding today's hearing on reforming Medicare provider payment, including consideration of the Ensuring Community Access to Pharmacist Services Act (ECAPS)(H.R. 3164).

The American Society of Health-System Pharmacists (ASHP) is the largest association of pharmacy professionals in the United States, representing over 65,000 pharmacists, student pharmacists, and pharmacy technicians in all patient care settings, including hospitals, ambulatory clinics, and health-system community pharmacies. We thank you for today's hearing that will consider legislation that will ensure seniors access to care provided by their pharmacist.

Pharmacists are the most accessible healthcare provider for many seniors, serving as the first stop for medication-related concerns and preventing or mitigating the impacts of infectious disease. Yet because Medicare does not recognize pharmacists as providers under Part B, many seniors lack coverage for this essential care.

Pharmacists are the most accessible healthcare provider for many seniors, often providing the first point of contact for medication-related concerns and preventing or mitigating the impacts of infectious disease. Many seniors rely on pharmacists as a trusted source of care and support.

The Ensuring Community Access to Pharmacist Services (ECAPS) Act (H.R. 3164), would ensure that America's seniors continue to have access to these critical public health services by providing payment under Medicare Part B for pharmacist-provided testing and treatment for select respiratory conditions like influenza, respiratory syncytial virus, strep throat, and pneumococcal disease. **We support passage of this legislation, which would ensure Medicare patients have access to testing, vaccination, and treatment services for respiratory infections that pharmacists are authorized by their states to provide.**

We look forward to continuing to work with you on Medicare provider reform as well as ensuring American seniors have access these essential services. If you have questions or if ASHP can assist your office in any way, please contact Frank Kolb at fkolb@ashp.org.

Sincerely,

Tom Kraus
Chief Advocacy Officer
American Society of Health-System Pharmacists

Statement for the Record: The National Community Pharmacists Association

**U.S. House of Representatives Committee on Energy and Commerce,
Subcommittee on Health**

**Hearing: “Examining Legislative Proposals to Reform Medicare Provider Payment
and Bolster Health Care Security”**

September 15, 2026

Chairman Griffith, Ranking Member DeGette, Chairman Guthrie, Ranking Member Pallone,
and members of the subcommittee:

The National Community Pharmacists Association (NCPA) welcomes the opportunity to provide a statement for the record to the subcommittee hearing on ways to identify solutions to address challenges in the Medicare payment landscape. We are encouraged to see H.R. 3164, the Ensuring Community Access to Pharmacist Services Act, included in the bills under consideration. NCPA represents America’s community pharmacists, including nearly 19,000 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care (LTC) settings. Together, our members represent a \$103 billion health care marketplace, employ 235,000 individuals, and provide an expanding set of health care services to millions of patients every day. Our members are small business owners who are among America’s most accessible health care providers.

Independent pharmacists play a vital role in addressing health care access challenges and improving patients’ health outcomes. As trusted health care providers, pharmacists are often the most accessible health care professionals in rural and underserved communities. They provide essential services, including medication therapy management, immunizations, chronic disease management, and preventive care screenings, helping patients manage their health conditions and avoid costly hospitalizations. Research from the University of Southern California-NCPA Pharmacy Access Initiative shows that across the country, roughly one in eight neighborhoods are pharmacy shortage areas¹, and when a pharmacy shortage area gains pharmacy access, it is most likely due to an independent

¹ Rozelle, J.W., Vos, R.O., Guadamaz, J.S.; Veetil, S.K.O.; & Qato, D.M. (YEAR, MONTH DATE). Pharmacy Shortage Areas Map (Version 2.3) University of Southern California and National Community Pharmacists Association (USC-NCPA) Pharmacy Access Initiative. <https://pharmacydeserts.com>

pharmacy opening. In fact, nearly two-thirds of independent pharmacies collectively serve areas with a population of less than 50,000. Pharmacists have more medication-related education and training than any other health care professional.

For these reasons we were pleased to see the inclusion of H.R. 3164 in this hearing. This legislation, introduced by Reps. Adrian Smith (R-Neb.), Brad Schneider (D-Ill.), Diana Harshbarger (R-Tenn.) and Doris Matsui (D-Calif.), is an NCPA policy priority as it would ensure Medicare beneficiaries can easily access health care services by authorizing pharmacists to test and treat COVID-19, flu, respiratory syncytial virus, and strep throat, and ensure pharmacists are reimbursed for providing those services.

This legislation protects patient access, especially for people in rural areas where pharmacists can be the only health care provider for many miles. These policies recognize pharmacists and the role they have in improving health care access by establishing direct reimbursement via Medicare Part B for providing these services. Independent pharmacies have played a large role at both the federal and state levels in testing for COVID-19 and administering COVID-19 vaccines to those in their communities and in long-term care facilities, and this legislation would ensure continued access for patients to services at their local pharmacy.

It is important to note that pharmacists can already test and treat in 36 states and the District of Columbia, including independent prescribing of medications pursuant to a CLIA-waived test in 20 states.² This means that in these states, it is our seniors who are going without care, solely because the federal government has not kept up with the states. It is a detriment to our seniors that as soon as they go on the mandated government services in their state, they lose this access. Increased utilization of pharmacists' services has improved patient outcomes and reduced overall health care costs. Systematic reviews have indicated positive returns on investment when evaluating broader pharmacist services, with up to \$4 in benefits for every \$1 invested in clinical pharmacy services.³

Within the next 10 years, the U.S. could see a shortage of over 55,000 primary care physicians.⁴ Pharmacists across the country are ready to provide valuable health care

² <https://naspa.us/resource/pharmacist-prescribing-for-strep-and-flu-test-and-treat/>

³ Murphy E, Rodis J, Mann H. Three ways to advocate for the economic value of the pharmacist in health care. *J Am Pharm Assoc.* 2020; 60, e116-e124.

⁴ Association of American Medical Colleges. 2019 UPDATE The Complexities of Physician Supply and Demand Projections From 2017 To 2032. Available at: https://aamcblack.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-

services to these communities that have limited access to care.⁵ By realigning financial incentives federally, in the states that already allow this care outside of Medicare, reimbursing pharmacists for their services similar to other health care professionals means there will be greater access to the vital health care services pharmacists provide.

Over the years, the pharmacy profession has evolved from a dispensing and product reimbursement industry to a profession with training and patient relationships to provide outcomes-based services and participate in care coordination efforts. Pharmacists undergo a minimum of six years of comprehensive undergraduate and professional education, with training in clinical services, disease state management, and interpretation of lab data. Pharmacists' care has increasingly involved patient counseling, and we have learned how their presence in underserved communities has seen improved health outcomes and reduced health care costs.

This legislation does not change the standard of care practices in the states. Instead, it allows for pharmacists to be reimbursed for providing our services for these four specific conditions to seniors in Medicare in the states that already allow these practices. This does not eliminate care coordination or communication with other health care providers. Pharmacists remain responsible for appropriate documentation, referral, follow-up, and communication with patients.

Pharmacists are already an integral part of the health care team and often have more frequent contact with patients than other providers. Allowing pharmacists to address appropriate medication-related and preventive care needs can help close gaps in care rather than create them, particularly when patients face long wait times or limited access to other providers. Additionally, pharmacists are responsible for practices within their own professional capacity and remain licensed health professionals subject to board oversight, disciplinary authority, applicable state and federal law, and professional accountability.

Substantial published literature documents the significant improvement to patient outcomes and reduction in health care expenditures¹ when pharmacists are more optimally leveraged.⁶ Studies have found themes in these cost savings, including "decreased total

[294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf](#)

⁵ Bureau of Labor Statistics. Occupational Employment Statistics Query System. Available at: <https://data.bls.gov/oes/#/home>.

⁶ Giberson S, Yoder S, Lee MP. Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011. Available at: https://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf

health expenditures, decreased unnecessary care (e.g., fewer hospitalizations, emergency department [ED] visits, and physician visits), and decreased societal costs (e.g., missed or nonproductive workdays).” In states where such legislation has already been implemented, we are observing health plans, notably Medicaid managed care organizations, recognizing the value of the pharmacist and investing in the services they provide. This again should be an incentive to allow our seniors, often those in the most need of health care services, to be able to go to their pharmacist for testing and treating of these four conditions.

It is imperative that Congress enact legislation promptly to address this disparity for our seniors, and we urge you to work with your colleagues on final passage and enactment. This bill will ensure that more patients have greater access to health care services provided by pharmacists while supporting the sustainability of local pharmacies in our communities. The adoption of this important legislation will ensure that seniors across the country are able to receive vital health care services provided by their pharmacist.

We applaud the bipartisan, bicameral efforts to expand access to vital services for seniors, and we urge lawmakers to continue to work in a bipartisan manner to pass these reforms. We commend the Committee on Ways and Means for marking up this bill in May, and we hope that this hearing will build on that legislative momentum to provide legislative relief this Congress. Thank you for your attention. Please contact Anne Cassity (anne.cassity@ncpa.org), Kaite Krell (kaite.krell@ncpa.org), or David Weissman (david.weissman@ncpa.org) with any questions you may have.



September 14, 2026

The Honorable John Joyce, MD
U.S. House of Representatives
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Murphy, MD
U.S. House of Representatives
407 Cannon House Office Building
Washington, DC 20515

The Honorable Kim Schrier, MD
U.S. House of Representatives
1110 Longworth House Office Building
Washington, DC 20515

RE: H.R. 9693 Patients First Act - SUPPORT

Dear Representatives Joyce, Murphy, and Schrier:

On behalf of the American Academy of Sleep Medicine (AASM), I am pleased to express our support for H.R. 9693, the "Patients First Act." This bipartisan legislation would help stabilize the Medicare physician payment system and move Congress away from the cycle of temporary patches and recurring payment uncertainty that threatens access to care.

AASM strongly supports the bill's permanent annual payment update tied to the Medicare Economic Index, as well as provisions to modernize budget neutrality, correct inaccurate utilization assumptions, and update practice-expense inputs in consultation with physician specialty societies. These reforms are essential to ensuring that Medicare payment better reflects the real costs of delivering care and protects beneficiaries' access to physician services.

These issues are especially important in the practice of sleep medicine. Sleep physicians provide diagnostic testing, interpretation of physiologic data, longitudinal management of chronic sleep disorders, device-based therapies, and coordination with primary care and other specialists.

AASM supports replacing MIPS with a more clinically meaningful quality framework that places physicians and specialty societies at the center of measure development,

while also encouraging Congress to make targeted modifications that ensure reforms intended to promote quality and efficiency appropriately reflect the clinical realities of specialty care. For sleep medicine, specialty input is essential to ensure that quality, resource use, and care-efficiency measures are grounded in evidence-based guidelines and account for the complexity of care, including diagnostic testing, interpretation of physiologic data, longitudinal management, patient adherence, device-based therapies, and coordination with primary care and other medical specialties.

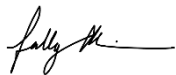
Additionally, the AASM also supports the bill's focus on care efficiency and value-based care. Sleep medicine can reduce unnecessary utilization through clinically appropriate models such as unattended sleep testing, telehealth follow-up for positive airway pressure therapy, remote monitoring, and virtual patient education. Congress should ensure these pathways preserve physician judgment and access to facility-based testing or other medically necessary services when clinically indicated.

To prevent unintended consequences, care-efficiency measures should include specialty-specific risk adjustment, appropriate attribution, adjustment for patient complexity, and exclusion of costs outside the specialist's reasonable control. Quality measures should align with clinical practice guidelines and be validated by the affected specialty before influencing payment.

Together, these reforms would help create a more stable, sustainable, and patient-centered Medicare physician payment system.

We commend your bipartisan leadership in introducing this important legislation and urge Members of Congress to join you in supporting H.R. 9693. We look forward to working with you and your colleagues to advance reforms that strengthen Medicare, support physician practices, reduce unnecessary administrative burden, and preserve access to high-quality care for patients with sleep disorders. Please contact Eric Albrecht, Senior Advocacy Program Manager, at ealbrecht@aasm.org or 630-737-9700 with any questions.

Sincerely,



Sally Ibrahim, MD FAAP FAASM
AASM Advocacy Chair

**Written Statement for the Record
American Nurses Association
“Examining Legislative Proposals to Reform Medicare Provider Payment
and Bolster Health Care Cybersecurity”
U.S. House Energy and Commerce Health Subcommittee**

September 15, 2026

The American Nurses Association (ANA) appreciates the opportunity to submit this statement for the record regarding the House Energy & Commerce Health Subcommittee Hearing, “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity”. ANA thanks the Subcommittee for including **H.R. 1616, the *Promoting Access to Diabetic Shoes Act***, and is pleased to voice its strong support for this legislation. ANA commends Representatives Darin LaHood and Nanette Barragán for their leadership in advancing this important bill that will improve Medicare beneficiaries’ access to care by allowing nurse practitioners (NPs) to document a patient’s need for therapeutic shoes without requiring an additional physician visit for documentation.

ANA also recognizes the Subcommittee’s continued focus on Medicare provider payment reform through inclusion of **H.R. 9693, the *Patients First Act of 2026***. ANA looks forward to continuing to work with the bill sponsors and the Subcommittee to further improve the legislation and build on the advances it makes to ensure longstanding, meaningful, and patient-centric reforms that reflect the realities of today’s healthcare system and appropriately recognize the vital contributions of nurses and all healthcare providers.

ANA is the premier organization representing the interests of the nation’s more than five million registered nurses (RNs) through its constituent and state nurses associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, supporting the health and wellness of nurses, and advocating on healthcare issues affecting nurses and the public. ANA members include the four advanced practice registered nurse (APRN) roles: NPs, clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). Nurses serve in direct care, care coordination, administration, and leadership roles across the full spectrum of healthcare settings.

APRNs are essential to delivering timely, high-quality care to Medicare beneficiaries, particularly in rural and medically underserved communities. NPs alone conduct more than one billion patient visits annually and represent more than 40 percent of the primary

care workforce. Yet, outdated Medicare statutory and regulatory barriers continue to unnecessarily constrain APRN practice and can make it more difficult for patients to receive care from the qualified healthcare professionals they trust and rely on. H.R. 1616 offers a commonsense example of how Congress can remove one such barrier and better align Medicare policy with today's healthcare workforce.

Therapeutic footwear is an important component of care for eligible Medicare beneficiaries with diabetes and severe diabetes-related foot disease. Under current law, a physician must certify a beneficiary's need for therapeutic footwear, even when an NP is managing the patient's diabetes. As a result, patients may be required to have an additional physician visit for evaluation and certification, despite already receiving diabetes care from an NP. This duplicative and unnecessary requirement can delay access to care that can prevent diabetes-related complications, create additional administrative burden, and may result in added costs for patients and the Medicare program, while failing to recognize the clinical role of NPs in managing diabetes and other chronic conditions.

H.R. 1616 would modernize Medicare policy to allow NPs to satisfy documentation requirements for Medicare coverage of therapeutic shoes for individuals with diabetes. The bill does not create a new Medicare benefit. Rather, it updates federal policy to appropriately recognize NPs for purposes of documenting a patient's need for an existing Medicare benefit, helping patients receive necessary care without the additional and unnecessary step of seeing a physician solely to satisfy a documentation requirement.

ANA urges the Subcommittee to advance H.R. 1616 and continue working to eliminate unnecessary federal barriers that prevent nurses and other qualified healthcare professionals from practicing to the full extent of their education and training. ANA has long identified a myriad of reforms that will improve access to care, reduce unnecessary administrative burden, and ensure Medicare policy better reflects how healthcare is delivered today.

ANA recognizes the Subcommittee for its leadership and for its willingness to consider our perspective on this critical issue. We stand ready to work with you to advance policies to further improve the Medicare program and the beneficiaries it serves. Please contact Tim Nanof, ANA's Executive Vice President for Policy and Government Affairs, at Tim.Nanof@ana.org with any questions.

Statement for the Record

House Energy & Commerce Subcommittee on Health *“Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity”*

September 15, 2026

Submitted by the American College of Cardiology

The American College of Cardiology (ACC) appreciates the opportunity to submit this statement for the record on *“Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity.”* The ACC is a global leader dedicated to transforming cardiovascular care and improving heart health for all. For more than 75 years, the ACC has empowered a community of more than 60,000 cardiovascular professionals with cutting-edge education and advocacy, rigorous professional credentials, trusted clinical guidance, world-class JACC Journals, National Cardiovascular Data Registry (NCDR), Accreditation Services, global Chapters and Sections, and CardioSmart patient initiatives.

The ACC appreciates the Committee’s continued bipartisan attention to the long-standing challenges facing the Medicare physician payment system. Cardiovascular clinicians are practicing in an increasingly unstable payment environment characterized by inadequate statutory updates, rising practice costs, budget neutrality pressures, administrative burdens, and limited opportunities for specialists to participate meaningfully in value-based care. These pressures affect not only the financial stability of physician practices but also patients’ ability to access timely, high-quality cardiovascular care.

The legislative proposals under consideration today provide Congress with an important opportunity to modernize Medicare physician payment and quality programs, strengthen the infrastructure clinicians use to improve patient outcomes, and address persistent barriers to care. In particular, the ACC strongly supports the *Access to Claims Data Act* (H.R. 4331), the *Provider Reimbursement Stability Act* (H.R. 8163), and the *Rural Obstetrics Readiness Act* (H.R. 1254). At the same time, the ACC opposes the *Radiology Outpatient Ordering Transmission (ROOT) Act* (H.R. 5737) and urges the Committee to remove the corresponding Appropriate Use Criteria provision from Section 207 of the *Patients First Act* (H.R. 9693).

Modernizing Medicare Physician Payment Through the *Patients First Act*

The ACC appreciates the Committee’s broader effort to modernize the *Medicare Access and CHIP Reauthorization Act (MACRA)* and believes the *Patients First Act* (H.R. 9693) contains numerous reforms that can help create a more stable, clinically meaningful Medicare payment system.

President
Roxana Mehran, MD, FACC

Vice President
Hani K. Najm, MD, MSc, FACC

Immediate Past President
Christopher M. Kramer, MD, MACC

Treasurer
Akshay K. Khandelwal, MD, MBA, FACC

Secretary and Board of Governors Chair
Renuka Jain, MD, FACC

Board of Governors Chair-Elect
Dinesh Kalra, MD, FACC

Trustees
Lee R. Goldberg, MD, MPH, FACC
Samuel O. Jones, IV, MD, MPH, FACC
Fred M. Kusumoto, MD, FACC
Bonnie Ky, MD, MSCE, FACC
Sandra J. Lewis, MD, FACC
Andreas Merkl, MBA
Pamela B. Morris, MD, FACC
Andrea L. Price, MS, CPHQ, FACC
Geoffrey A. Rose, MD, FACC

Chief Executive Officer
Cathleen C. Gates

The Mission of the American College of Cardiology and the American College of Cardiology Foundation is to transform cardiovascular care and improve heart health for all.

Cardiology practices continue to face significant pressure from rising practice expenses and an underlying physician payment system that has not kept pace with the cost of delivering care. These challenges are compounded by Medicare's budget neutrality requirements, payment volatility, burdens associated with the Merit-based Incentive Payment System (MIPS), and the difficulty many specialists experience participating meaningfully in Alternative Payment Models (APMs).

The ACC supports moving toward more predictable physician payment updates that better reflect changes in the cost of practicing medicine. We also support efforts to make Medicare quality measurement more clinically meaningful and specialty informed. Quality and cost measures should be aligned with evidence-based guidelines, appropriately account for patient complexity, and provide clinicians with timely and actionable information they can use to improve patient care. Cardiologists often care for patients with multiple chronic conditions and rely on testing, imaging, procedures, devices, and ongoing management to prevent costly complications, hospitalizations, stroke, and death. Measures must therefore distinguish appropriate, guideline-directed care from unnecessary utilization.

The ACC also supports the ***Patients First Act***'s efforts to improve MIPS and reduce administrative burden, including protections against excessive penalties during the transition to a reformed performance measurement system. Significant changes to physician performance measurement should be accompanied by appropriate safeguards while new measures, reporting mechanisms, and performance expectations are developed and implemented.

Similarly, ACC supports policies that expand opportunities for specialists to participate in appropriately designed value-based payment models. Cardiovascular clinicians play an essential role in managing some of Medicare's most complex and costly chronic conditions, yet many current APMs do not provide viable pathways for specialty participation. The ***Patients First Act***'s attention to APM participation and the barriers specialists face represents an important step toward ensuring that value-based care works for the full range of clinicians participating in Medicare.

Finally, the ACC supports greater transparency and predictability in Center for Medicare and Medicaid Innovation models and reforms to Medicare Physician Fee Schedule (PFS) budget neutrality, practice expense inputs, and conversion factor volatility. Taken together, these policies provide a strong bipartisan package that could improve physician payment stability while strengthening quality and value for Medicare beneficiaries.

Improving Quality Through the *Access to Claims Data Act*

Among the policies before the Committee, the ***Access to Claims Data Act*** (H.R. 4331) is a particularly important priority for the ACC. This bipartisan legislation would improve patient outcomes, quality of care, and data-driven research by providing clinician-led clinical data registries with better access to federal health program claims data.

For more than 25 years, the ACC's National Cardiovascular Data Registry (NCDR) has helped clinicians, hospitals, and health systems improve cardiovascular care through real-world evidence, benchmarking, quality improvement, and outcomes research. However, regulatory limitations restricting access to comprehensive claims data make it difficult for clinical registries to evaluate long-term patient outcomes and the effectiveness of treatments beyond an individual episode of care. These limitations constrain quality improvement and patient safety initiatives and prevent clinicians and researchers from realizing the full potential of the clinical information already being collected.

H.R. 4331 would address these barriers by directing the Secretary of Health and Human Services to establish a process through which qualified clinician-led registries can regularly and securely access claims information from Medicare, Medicaid, and the Children's Health Insurance Program. Importantly, the legislation would remove unnecessary administrative and financial barriers while allowing access at a reasonable fee and without requiring registries to qualify as quasi-qualified entities.

The ACC believes combining high-quality clinical registry information with claims data can produce a more complete understanding of the patient journey. Better longitudinal information allows clinicians and researchers to identify gaps in care, evaluate patient outcomes, improve patient safety, assess the effectiveness of treatments, and translate evidence into improved clinical practice. The ACC therefore strongly urges the Committee to advance H.R. 4331 and preserve policies expanding access to claims data as part of any broader Medicare reform package.

Stabilizing the Medicare Physician Fee Schedule

The ACC also strongly supports the ***Provider Reimbursement Stability Act*** (H.R. 8163). Medicare physician payment has become increasingly disconnected from the cost of maintaining a medical practice. American Medical Association data show that, after adjusting for inflation, Medicare physician reimbursement has declined by more than 33 percent since 2001, even as practice expenses have increased by more than 60 percent over the same period. Since 2021, cuts to physician reimbursement have resulted in an estimated \$700 million in lost payments for cardiology services. This divergence is not sustainable and increasingly threatens practices' ability to invest in their workforce, technology, and infrastructure while maintaining patient access.

H.R. 8163 would make several important improvements to Medicare's budget neutrality policies. The legislation would raise the existing \$20 million budget neutrality threshold to \$54.3 million. That threshold has not been updated or adjusted for inflation since it was established in 1989. The bill would also require the threshold to be increased by the cumulative Medicare Economic Index (MEI) at least every five years, allowing Medicare to make reasonable pricing adjustments without unnecessarily triggering broad reductions to the conversion factor.

The legislation would also require the Centers for Medicare and Medicaid Services (CMS) to update direct cost inputs used to calculate practice expense relative value units at least every five years and limit year-to-year changes to the Medicare conversion factor to no more than 2.5 percent. These reforms would help reduce disruptive payment swings, improve the accuracy of Medicare payment, and give physician practices greater ability to plan for the future.

These changes do not resolve every challenge facing the PFS, but they represent meaningful reforms to an outdated budget neutrality framework. The ACC urges Congress to advance H.R. 8163 and continue working toward a Medicare payment system that provides physicians with stable and predictable updates reflecting the actual cost of caring for patients.

Strengthening Rural Maternal and Cardiovascular Care

The ACC also supports the ***Rural Obstetrics Readiness Act*** (H.R. 1254). Access to appropriate care in rural communities remains an important component of strengthening the health care system, particularly for pregnant and postpartum patients who may experience cardiovascular complications.

According to the March of Dimes, more than 2.3 million women live in communities without access to essential maternity care. H.R. 1254 would address these gaps through targeted investments in clinician training, lifesaving equipment, and regional teleconsultation networks to support urgent maternal health needs. These investments would help ensure that patients can receive timely and appropriate treatment before, during, and after pregnancy regardless of where they live.

This issue is particularly important to the cardiovascular community. Cardiovascular disease is a serious cause of pregnancy-related death and complications in the United States, with rural and underserved communities facing significant challenges. The ACC supports team-based, interdisciplinary care and evidence-based protocols for pregnant and postpartum patients with cardiovascular conditions. H.R. 1254 would advance these goals by strengthening clinicians' ability to respond to obstetric emergencies, including hypertensive disorders and cardiac complications of pregnancy.

The ACC urges swift passage of H.R. 1254. Strengthening the training, infrastructure, equipment, and clinical connectivity available to rural health professionals can help prevent avoidable complications and improve outcomes for mothers and infants.

Opposing the *ROOT Act* and a New Stand-Alone Appropriate Use Criteria (AUC) Mandate

While the ACC supports the many constructive reforms included in the *Patients First Act* (H.R. 9693), we have significant concerns regarding Section 207 and strongly oppose the *Radiology Outpatient Ordering Transmission (ROOT) Act* (H.R. 5737).

The ACC supports the development and use of AUC as tools to promote evidence-based, patient-centered care. Professional societies, including the ACC, have invested considerable expertise in developing clinical guidance to help clinicians select appropriate diagnostic testing and treatment. AUCs are most effective, however, when integrated into broader quality improvement and value-based care efforts, not when imposed through a stand-alone federal consultation and reporting mandate.

Experience with the AUC program established by the *Protecting Access to Medicare Act* demonstrated the operational and policy challenges inherent in such an approach. CMS ultimately determined that a separate AUC consultation mandate was not the most effective or efficient means of improving appropriate imaging utilization and instead emphasized more integrated approaches through existing quality programs.

The *ROOT Act* would revive many of these concerns. Although the legislation addresses certain technical issues associated with the previous program, its continued reliance on CMS-qualified clinical decision support mechanisms could limit clinicians' ability to use the AUC most relevant to their specialty and their patients. During the previous testing period, specialists sometimes could not consult criteria developed by their own professional societies because the clinical decision support systems purchased by their hospitals or health systems did not make those criteria available.

AUC developed by different provider-led organizations, can also vary considerably in methodology, clinical scenarios, and appropriateness ratings. In coronary artery disease alone, an analysis cited by the physician community found substantial variation among seven provider-led entities in the number of clinical scenarios used to evaluate cardiac symptoms.

Most importantly, requiring physicians to complete a separate formal AUC consultation for routine imaging within their area of specialty expertise risks adding another repetitive administrative task without demonstrating a corresponding improvement in clinical decision-making. Effective use of decision-support

systems also requires education, workflow integration, and resources to ensure that appropriate clinical information is entered into the system—issues not adequately addressed by either the **ROOT Act** or the corresponding **Patients First Act** provision.

These requirements run counter to the broader goals of the **Patients First Act**. The legislation's reforms to MIPS seek to reduce administrative burden and ensure that physicians are evaluated on measures relevant to their specialties and the care they provide. Adding a new, siloed reporting requirement for AUC would move in the opposite direction.

For these reasons, the ACC opposes H.R. 5737 and respectfully urges the Committee to remove Section 207 from H.R. 9693. Doing so would preserve the broader bipartisan and consensus-oriented reforms contained in the **Patients First Act** while allowing Congress, medical specialty societies, and other stakeholders to continue discussing how best to incorporate AUC into meaningful quality improvement initiatives. The ACC welcomes further dialogue on AUC policy and believes any future approach should be clinically relevant, specialty informed, focused on education and quality improvement, and designed to minimize unnecessary administrative burden.

Conclusion

The Committee has an important opportunity to advance meaningful bipartisan reforms that strengthen Medicare for both patients and the clinicians who care for them. The ACC urges Congress to advance the **Patients First Act** (H.R. 9693) while removing Section 207; pass the **Access to Claims Data Act** (H.R. 4331) to give clinician-led registries the information needed to improve quality, safety, and outcomes; enact the **Provider Reimbursement Stability Act** (H.R. 8163) to modernize Medicare's outdated budget neutrality policies and reduce payment volatility; and advance the **Rural Obstetrics Readiness Act** (H.R. 1254) to strengthen care for pregnant patients in rural communities. At the same time, the ACC urges Congress not to advance the **ROOT Act** (H.R. 5737) or impose a new stand-alone AUC mandate.

Taken together, these reforms can move Medicare toward a payment and quality framework that is more predictable for clinicians, more meaningful for specialists, less administratively burdensome, and better equipped to deliver high-quality care for patients. The ACC looks forward to continuing to work with the Committee and Congress to advance these priorities and ensure that patients remain at the center of Medicare reform. The ACC appreciates the opportunity to provide this statement and stands ready to work with the Committee to advance meaningful reforms that improve patient care and support the clinician workforce.

The American College of Cardiology (ACC) is a global leader dedicated to transforming cardiovascular care and improving heart health for all. For more than 75 years, the ACC has empowered a community of over 60,000 cardiovascular professionals across more than 140 countries with cutting-edge education and advocacy, rigorous professional credentials, and trusted clinical guidance. From its world-class JACC Journals and NCDR registries to its Accreditation Services, global network of Chapters and Sections, and CardioSmart patient initiatives, the College is committed to creating a world where science, knowledge and innovation optimize patient care and outcomes. Learn more at www.ACC.org or connect on social media at @ACCinTouch.

September 14, 2026

The Honorable Brett Guthrie
Chairman
Committee on Energy & Commerce

The Honorable Frank Pallone
Ranking Member
Committee on Energy & Commerce

The Honorable Morgan Griffith
Chairman
Subcommittee on Health

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health

Dear Chairman Guthrie, Ranking Member Pallone, Subcommittee Chairman Griffith, and Ranking Member DeGette:

On behalf of March of Dimes, the nation's leading nonprofit organization fighting for the health of all moms and babies, I write to express our strong support for the Rural Obstetrics Readiness Act (H.R. 1254) sponsored by Rep. Robin Kelly. We appreciate your leadership in including this important legislation in this week's legislative hearing.

The U.S. is among the most dangerous developed nations for childbirth, especially for those who are Black, American Indian/Alaska Native, live in maternity care deserts, or are insured by Medicaid. Our "Nowhere to Go: Maternity Care Deserts Across the U.S." (2026 report) finds that 1 in 3 U.S. counties remains a maternity care desert. In total, 5.8 million women and 358,000 infants live in counties without full access to maternity care.¹ The report found at least 96 hospital labor and delivery units closed across 35 states between 2024 and early 2026. In nearly 60% of affected counties, the closed unit was the community's only birthing facility. These closures increased average travel time to maternity care by 25 minutes in affected communities. Rural and under-resourced communities continue to face the greatest barriers. More than half of U.S. counties lack a hospital with labor and delivery services, and residents of maternity care deserts travel approximately three times longer to reach one than residents of full-access counties.

The Rural Obstetrics Readiness Act would help close these gaps in rural areas by funding emergency training, equipping non-obstetric facilities, and expanding telehealth. Key provisions include federal grants for equipment, specialized training for rural staff, and pilot programs for urgent teleconsultation, with a focus on areas lacking dedicated obstetric units. This legislation contains a set of policies to improve obstetrical readiness that does not duplicate existing programs and would provide critical resources to communities facing significant barriers to needed healthcare with declining access to obstetric services. While it is not a solution to the systemic loss of labor and delivery units and hospital closures that are putting facilities for high-risk pregnancies out of reach for families, it would assist many communities that have experienced closures and have a shortage of maternity care professionals.

¹ Stoneburner A, Chestnut JF, Lucas R, Jones EE, DeMaria AL. "Nowhere to Go: Maternity Care Deserts Across the U.S." Report No. 5. March of Dimes, 2026. <https://www.marchofdimes.org/maternity-care-deserts-report>

We urge the committee to advance the Rural Obstetrics Readiness Act to address the growing trend of maternity care deserts caused by labor and delivery unit closures that are further limiting access to maternity care for families in rural communities. Its passage would be a meaningful step toward reducing preventable maternal death and pregnancy complications and building a healthy future for mothers and babies across the country. For more information, please contact KJ Hertz (khertz@marchofdimes.org).

Sincerely,



Stacey Y. Brayboy
Sr. Vice President, Public Policy & Government Affairs

CC:
All Members of the House Energy & Commerce Committee

WRITTEN STATEMENT OF CATHERINE HEEGE

Alzheimer's Advocate & Caregiver

Forest Hills, NY 11375

To Chairman Guthrie, Subcommittee Chairman Griffith, and Distinguished Members of the Subcommittee on Health:

Thank you for convening this vital hearing and for placing H.R. 6130, the Alzheimer's Screening and Prevention (ASAP) Act, on the legislative agenda. I submit this testimony as an active advocate, community volunteer, and most importantly as a daughter who experienced firsthand the systemic hurdles of navigating a loved one's dementia journey.

When families first notice cognitive decline, time is everything. Yet, under current practice, receiving an accurate diagnosis often resembles an exhausting obstacle course. Patients endure months of waiting lists, invasive procedures, expensive specialized imaging, and fragmented specialist referrals. Far too often, an accurate diagnosis arrives late in the disease's progression after irreversible damage has occurred, after the window for newer FDA approved therapeutics has closed, and after families have spent critical months in emotional and financial freefall.

The ASAP Act offers a transformative step forward. By modernizing Medicare to provide permanent coverage for FDA reviewed, blood based screening tests, H.R. 6130 clears the administrative roadblocks standing between our seniors and early detection.

Routine blood work is familiar, accessible, and vastly less burdensome for both patients and clinicians. Just as Medicare coverage for routine mammograms fundamentally altered the trajectory of breast cancer detection, making blood based dementia screening an accessible Medicare benefit will democratize brain health.

An early diagnosis does not just open the door to newly available disease modifying treatments; it grants families something irreplaceable: agency and time.

- It gives patients the dignity to participate in their own financial, legal, and care decisions while their voices are strongest.
- It gives family caregivers the ability to plan, build support networks, and avoid crisis driven hospitalizations.
- It enables earlier intervention that can preserve independence and quality of life for months or years longer.

Our healthcare system cannot continue to leave older adults and their families to pay out of pocket for modern diagnostics while promising treatments move forward. The science has advanced, and our federal reimbursement frameworks must keep pace not only for the sake of patients, but for the financial health of the Medicare system itself. When a

simple blood based biomarker test costs a few hundred dollars, forcing the system and patients to rely on invasive lumbar punctures or \$3,000 plus PET scans is economically unsustainable. By covering these less expensive, highly accurate blood tests, H.R. 6130 creates a rare legislative win win: expanding critical access for older Americans while delivering substantial, immediate cost savings for the federal government.

On behalf of the millions of Americans living with Alzheimer's and related dementias, and the dedicated family caregivers walking beside them, I respectfully urge the Subcommittee to swiftly advance H.R. 6130.

Thank you for your leadership and for including this perspective in the official hearing record.

Respectfully submitted,

Catherine Heege

Volunteer Advocate, Alzheimer's Association
Forest Hills, NY 11375



**Statement for the Record
Patrick Giam, M.D., FASA
President
American Society of Anesthesiologists**

**U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Hearing on
"Examining Legislative Proposals to Reform Medicare Provider Payment
and Bolster Health Care Cybersecurity"
September 15, 2026**

On behalf of the more than 60,000 members of the American Society of Anesthesiologists (ASA), I write to express our support for H.R. 9693, the Patients First Act of 2026, with targeted improvements discussed below, and H.R. 8163, the Provider Reimbursement Stability Act of 2026.

For too long, Medicare has undervalued physician services, with payment for anesthesia care provided by anesthesiologists remaining persistently and unreasonably low. These bills represent the most significant effort in more than a decade to address the longstanding structural flaws in the Medicare physician payment system and to establish a more stable, predictable, and sustainable payment framework. ASA has long advocated for reforms that better account for the rising costs of delivering care, preserve patient access to physician-led services, and strengthen anesthesiologists' practices that serve communities across the country.

Most importantly, the Patients First Act would establish permanent annual physician payment updates tied to the Medicare Economic Index (MEI), replacing the current cycle of recurring payment reductions and temporary legislative interventions. By creating an annual update mechanism linked to physician practice costs, the legislation would provide greater predictability for physician practices while helping ensure that patients continue to have access to timely, high-quality care. At a time when inflation continues to place pressure on the health care system, establishing a stable payment framework is essential to maintaining access for Medicare patients and strengthening the physician practices on which they rely.

ASA also supports reforms within the Patients First Act to improve Medicare's physician quality and value programs. The legislation would replace the flawed Merit-based Incentive Payment System (MIPS) with the Patient Outcome Improvement National Tabulation

System (POINTS), creating a more physician-led and clinically meaningful approach to quality measurement. Notably, ASA supports preserving the role of Qualified Clinical Data Registries (QCDRs), such as ASA's National Anesthesia Clinical Outcomes Registry (NACOR), the nation's largest anesthesia clinical data registry. QCDRs ensure meaningful physician and specialty society involvement in measure development and promote appropriate attribution and risk adjustment so physicians are evaluated on measures they can reasonably influence. These reforms would help reduce administrative burden while supporting quality improvement efforts that improve patient care and outcomes.

ASA recommends the following additional provisions to ensure that the POINTS system meets its full promise:

- **Explicitly Protect Physician-Led QCDRs.** Clarify that physician specialty societies and physician-led organizations may establish and operate Qualified Clinical Data Registries. The current cross-reference to “designated health care practitioners” could inadvertently exclude physicians and physician-led QCDRs.
- **Establish Physician-Led Specialty Subcommittees.** Require specialty subcommittees composed primarily of practicing physicians from the specialty affected by a quality measure. Anesthesiologists should have a meaningful role in determining whether anesthesia-specific measures are clinically valid, feasible, and appropriately attributed.
- **Guarantee Strong Physician Representation on the Task Force.** Require at least half of Task Force voting members to be practicing physicians and ensure direct representation from affected specialties when their measures are considered. Organizational representation alone should not substitute for participation by physicians with relevant clinical experience.
- **Ensure Task Force Approval Leads to Implementation.** Once a measure receives specialty subcommittee and Task Force approval, CMS should generally be required to implement it rather than conduct another substantive clinical review. CMS should be able to delay or reject an approved measure only for narrow, clearly defined reasons and with a written public explanation.
- **Strengthen Guardrails for Care-Efficiency Measures.** Physicians should only be held accountable for costs, utilization, referrals, and outcomes they can reasonably influence. This is particularly important for anesthesiologists, who often do not control the facility, procedure, surgeon, admission decision, or other major components of an episode's cost.

- **Protect Physicians from Technology and Reporting Failures.** Do not automatically assign the lowest quality score when reporting failures result from EHR systems, registry vendors, hospitals, or other circumstances outside the physician's control. The bill should include a meaningful hardship exception, including situations in which hospital-based physicians cannot obtain necessary facility-controlled data.
- **Revise the "Excluded Practice" Provisions.** Ensure physicians practicing in hospital- and facility-based settings are not subject to reduced POINTS adjustments based solely on their practice's ownership or organizational structure. This is especially important for anesthesiologists in academic medical centers, teaching hospitals, health systems, and other hospital-based practices.
- **Reform CMS' Treatment of "Topped-Out" Measures.** Grandfather clinically meaningful MIPS and QCDR measures into POINTS and do not eliminate a measure simply because performance is consistently high. Particularly for specialties with limited measure sets, continued widespread use and patient-safety value should weigh strongly in favor of retaining a measure.
- **Provide Measure Stability, Transition Time, and Transparency.** Require approved measures to remain available for at least five years and establish the Task Force and specialty review structure well before POINTS takes effect. CMS should also publish Task Force schedules, decisions, votes, and an implementation tracker so physicians can see exactly where approved measures stand.
- **Preserve Existing MIPS Exclusions.** Ensure that physicians who are currently excluded from MIPS, including those meeting the low-volume threshold and other existing exemptions, remain excluded under POINTS. The transition to a new quality program should not expand mandatory participation to physicians Congress and CMS have previously determined should be exempt.

ASA also strongly supports the Provider Reimbursement Stability Act of 2026. Medicare payment for anesthesia services has been significantly affected by the current budget-neutrality framework - a framework that can produce substantial payment volatility because of outdated statutory thresholds and inaccurate utilization assumptions. The legislation would modernize these policies by modestly increasing the budget-neutrality threshold, indexing that threshold over time, requiring CMS to reconcile projected and actual utilization when estimates prove inaccurate, ensuring more regular updates to direct practice expense inputs, and limiting excessive year-to-year fluctuations in the Medicare Physician Fee Schedule conversion factor. Together, these reforms could improve the stability, predictability, and accuracy of Medicare physician payment while

preserving Medicare's budget-neutrality requirements. These changes would also help reduce abrupt payment shifts that can disrupt physician practices, limit long-term planning, and ultimately threaten patient access to care.

Medicare patients depend on a physician payment system that supports access, stability, and quality. The Patients First Act and the Provider Reimbursement Stability Act would take meaningful steps toward modernizing Medicare physician payment by addressing both annual payment updates and the structural policies that contribute to payment instability.

ASA respectfully urges the Committee to advance these reforms and stands ready to work with Congress to ensure that Medicare continues to support high-quality patient care and a sustainable physician workforce for years to come.



September 15, 2026

STATEMENT FOR THE RECORD

H.R. 6214, the KIDNEY CARE ACCESS PROTECTION ACT

HOUSE COMMITTEE ON ENERGY & COMMERCE

SUBCOMMITTEE ON HEALTH

Introduction

Kidney Care Partners (KCP) is a non-profit coalition of more than 25 organizations, representing patients, dialysis professionals, physicians, nurses, researchers, therapeutic innovators, transplant coordinators, and manufacturers. KCP members are committed to meeting patients' needs at every stage along the care continuum, and our diverse membership shares a broad vision of policy priorities that range across the full spectrum of the kidney disease cycle from education and prevention through early intervention, treatment, dialysis, transplantation, and post-transplantation care.

KCP focuses on supporting patient choice and access in coverage options, treatment modalities, and innovative treatments and services, transforming Medicare to deliver more patient-centered care to beneficiaries with End Stage Renal Disease (ESRD), advancing quality to promote transparency and patient-centered decision-making, and ensuring access to high quality, innovative care for all individuals living with kidney disease.

More than 50 years ago, Congress extended Medicare coverage to Americans with ESRD regardless of age to ensure they have a stable source of coverage for the life-sustaining care they need. Since then, Congress has acted to promote better value, quality, and outcomes through payment policies, including the adoption of the ESRD Prospective Payment System (PPS) in 2011. KCP is especially pleased to support H.R.6214, *The Kidney Care Access Protection Act* (KCAPA), which would further modernize key payment policies with the important goal of advancing care innovations for beneficiaries living with ESRD. On March 18, 2026, KCAPA was discussed at a bipartisan hearing of the House Committee on Ways and Means Health Subcommittee titled "[Improving Kidney Health Through Better Prevention and Innovative](#)

KIDNEY CARE PARTNERS

25 Massachusetts Ave NW, Washington, DC 20001

www.kidneycarepartners.org | 202.250.1095

Treatment.”¹ We appreciate the opportunity to have a similar discussion at the Energy and Commerce Health Subcommittee.

Members and witnesses noted Congress’ “solemn responsibility” to make timely changes to the Medicare ESRD program, which has seen little material change over 50 years, essentially freezing care innovations in 20th century science. KCP strongly shares their view and believes KCAPA represents an important first step in modernizing a system that over 500,000 Medicare beneficiaries rely on to sustain life. KCP is grateful to the Energy and Commerce subcommittee for its consideration of the important improvements KCAPA would make for some of Medicare’s most vulnerable beneficiaries.

Overview of the Kidney Care Access Protection Act

Title 1 of KCAPA would refine the ESRD PPS to improve patient access to kidney care innovative treatment options by 1) aligning temporary add-on payment policies for new pharmaceutical therapies with similar add-on policies in other Medicare payment systems, providing a three-year add-on payment period to strengthen incentives for innovation and support providers in integrating new treatments into their care models, and subsequently modifying policy after the temporary period ends to ensure that providers have sufficient resources and beneficiaries have good access to pharmaceutical therapies they have come to rely on; 2) making important revisions to temporary add-on payment policies for innovative devices, equipment, and supplies by ensuring three years of add-on payments for innovative device technologies that improve the beneficiary care experience; 3) clarifying the definition of “renal dialysis services” to ensure products that do not treat ESRD are not pulled into the ESRD payment system; 4) clarifying that add-on payment eligibility for new and innovative devices, equipment, and supplies is available to support beneficiaries applies without the “capital asset” restriction to home dialysis that the Medicare program currently imposes²; and 5) ensuring that Medicare Advantage (MA) Organizations support kidney care innovative therapies by requiring that plans serving beneficiaries with ESRD adhere to the same add-on payment rules and policies governing dialysis care in the Traditional Medicare program, providing a “level playing field” for dialysis care between the two systems without adding new money for plans.

¹ A KCP press release congratulating the work of the subcommittee is available [here](#).

² Excluding new and innovative devices, equipment, and supplies that constitute capital assets has essentially halted innovation in this clinical area. Since the Medicare program began offering these temporary add-on payments in 2020, only one device’s technology has met the qualification for it. KCAPA would expand device therapy options and improve life quality for individuals with ESRD.

Title II of KCAPA addresses clinical staffing barriers arising from ESRD PPS deficiencies in market basket labor adjustments by ensuring accuracy and stability in kidney care payment. KCAPA would correct for growing gaps in Medicare's own forecasts for the costs of care and subsequent revisions to its forecasts based on actual, historical data. These growing gaps have resulted in significant underpayments to dialysis providers, especially in the highly competitive market for clinical labor.

Title III of KCAPA strives to prevent kidney disease and expand awareness and education about it by 1) expanding access to kidney disease screening; 2) increasing access to Medicare's kidney disease education (KDE) benefit for beneficiaries with Stage V chronic kidney disease (CKD) to address the clinical fact that CKD may progress rapidly, such that a beneficiary may progress to Stage V without having received a Stage IV diagnosis; and 3) by authorizing a physician assistant, nurse practitioner, or clinical nurse specialist assisting in the beneficiary's condition to provide KDE resources.

Kidney Care and Stagnation in Innovation

CKD and ESRD are serious conditions that typically come with co-morbidities that together make kidney disease a complex clinical and substantial economic burden to individuals and their families. The physical toll ESRD takes on individuals is severe, and innovations in dialysis care treatment that can improve life quality and patient care experience – in pharmaceutical and device therapies – have been minimal over time because current support from the Medicare system is insufficient, leaving patients behind.

Emerging therapies to support patients with ESRD have failed to flourish – and to improve patient life quality – not because the science does not exist or a lack of sincere commitment from physicians, researchers and allies, but because the current Medicare payment system for ESRD disincentivizes development and clinical adoption of new therapies by forcing them into a rigid, underfunded, “one size fits all” payment bundle too quickly, creating an unsustainable financial barrier for innovators to bring new therapies to patients. Although innovation in many areas of science has been transformative, there has been virtually no meaningful innovation in dialysis care, prompting nephrologists to call the dialysis care space an “innovation desert” and leaving patients receiving dialysis care with few if any new options to treat their condition. So little progress has been made that beneficiaries on dialysis have worse mortality than those with kidney cancer.

The singular deficiency in Medicare's ESRD PPS³ is the lack of a mechanism to pay for the adoption of new treatments. A flat “base rate” per dialysis session is merely updated by price

³ Congress last updated the ESRD PPS in the 2008 *Medicare Improvements for Patients and Providers Act* (MIPPA), which was implemented in 2011. MIPPA created the current bundled payment system that has failed to meet the needs of a growing and vulnerable population. The original cost inputs for the bundle date back to 2007, reflecting costs that prevailed 20 years ago.

proxies annually minus a productivity adjustment. These updates have failed to keep pace with the general medical inflation providers face each year, leaving little financial flexibility to modernize care. Having no sustained payment for better drugs, devices, equipment, and supplies, the care paradigm for patients with ESRD has changed little over decades, all while beneficiaries with other chronic conditions served by Medicare maintain wide access to breakthrough innovations that forestall or eliminate cardiac, rheumatoid, and other metabolic conditions, including cancers and rare diseases.

Medicare Efforts to Strengthen Innovation Have Failed Patients

In 2020, the federal Centers for Medicare and Medicaid Services (CMS) took important steps to modernize the Medicare ESRD PPS within MIPPA's framework when it created the Transitional Drug Add-on Payment Adjustment (TDAPA) and the Transitional Add-On Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) to provide payments to qualifying drugs, devices, equipment, and supplies that were market-based and added to the ESRD PPS base payment rate (about \$280 in 2026).

But in both instances, the add-on payments were generally only available for two years, and, in the case of TPNIES, only for certain devices, equipment, and supplies not considered "capital assets" of a dialysis provider other than those for home dialysis, a limitation that essentially foreclosed any device improvements in the dialysis care center.

The limited duration of TDAPA and TPNIES periods creates obstacles for the adoption of innovative therapies in dialysis care. Two years is not sufficient time for dialysis providers to assess the value of new treatment options for the beneficiaries they serve, conduct pilots in their facilities, evaluate real world impacts, establish new protocols, engage in contracts, and educate clinical staff.

Furthermore, and most importantly, physicians are generally unwilling to prescribe a new drug or device therapy if they are concerned that patients will lose access once the TDAPA or TPNIES period ends.

Following the temporary add-on payment period, dialysis facilities must make decisions about the adoption and continued use of new therapies within the broader context of their payment environment and the costs of providing comprehensive dialysis care. Ensuring a stable and predictable pathway for new therapies to transition into the ESRD PPS is therefore critical to supporting continued access to innovative treatments for Medicare beneficiaries.

The overall consequences of flaws in both the TDAPA and TPNIES fall unjustly on beneficiaries, who need dialysis care to remain alive and must suffer longer and with more acute symptomology that new drugs and devices would alleviate but, because of the limitations in TDAPA and TPNIES, remain unpalliated.

After the TDAPA – A Worsening Environment for Patients

In 2025, CMS finalized a reduced, post-TDAPA add-on payment that has proven unworkable. Based on the most recently available Medicare claims data, CMS takes total utilization of a new drug over a 12-month period and multiplies it by the current Average Sales Price (ASP) for the drug and then divides it by the total number of dialysis sessions nationwide, minus a discount of 35 percent. CMS applies the reduced post-TDAPA add-on to the base rate for each dialysis session, regardless of whether the new drug is utilized or not. After three years, no additional or sustained funding is provided.

This methodology for determining the payment amounts following the TDAPA period both dramatically underpays providers that might want to dispense the new drug, while directing Medicare dollars to those providers that do not. This payment conundrum occurs because the post-TDAPA add-on is allocated by CMS to providers based on their respective number of Medicare fee-for-service dialysis sessions and not aligned with their patients' actual TDAPA drug utilization.

While building the cost of certain commoditized products that are common to all dialysis sessions into the base rate is consistent with logic and economic practice, using the same process for payment of innovative new drugs during the post-TDAPA period, where implementation can vary widely across providers, is not.

There have been only four innovative dialysis drugs approved by the Food and Drug Administration (FDA) and granted TDAPA status by CMS since the start of the program. The first two drugs reached less than one percent of beneficiaries receiving dialysis during their TDAPA periods, despite significant unmet need among beneficiaries and the intent of TDAPA and post-TDAPA to address this need.

H.R. 6214, The Kidney Care Access Protection Act (KCAPA)

While this legislation is not a complete solution to the serious innovation challenges facing beneficiaries undergoing dialysis care, it is a critical and practical step that would improve patient access to new drug and device therapies today while Congress continues to examine longer-term reforms to this important, life-sustaining Medicare benefit.

First, it would extend the TDAPA and TPNIES adjustments from two to three years⁴, aligning these payment add-ons with those received for innovative therapies in the inpatient and outpatient hospital and ambulatory surgery settings of Medicare. Three years of separate payment would provide the time necessary for physician and provider adoption of a new drug or

⁴ Medicare allows three years for a new drug or device to receive pass-through payment under the Hospital Outpatient Prospective Payment System (OPPS) and the New Technology Add-on Payment (NTAP) adjustment in the Inpatient Hospital Prospective Payment System (IPPS).

device and allow for collection of robust data upon which to accurately establish payment amounts when the add-on payments expire. KCAPA would also ensure that beneficiaries with ESRD in MA plans receive access to the same innovations that their peers do in Traditional Medicare without providing new money to plans themselves.

Second, it would calculate the post-TDAPA add-on based only on patient treatments where the drug is used, and likewise, apply the add-on only for patients who use the drug. KCP believes that by changing the distribution of the same pool of expenditures by targeting payment to a product's actual use, patients would get needed therapies with marginal impacts on Medicare spending, and that the change would not be administratively complicated.

Third, KCAPA would clarify the definition of "renal dialysis services" to ensure treatments for cardiac disease, inflammatory conditions, cancer, diabetes, obesity, or other similar chronic or acute conditions are not swept into the ESRD PPS bundle, contrary to the Congressional intention of MIPPA, which can be the case with Administrative overreach.

Fourth, KCAPA would remove the "capital asset" limitation in TPNIES that has failed to open sustainable pathways for any innovation in in-center device therapy since its inception.

Fifth, KCAPA would provide fair and accountable reimbursement updates for providers tied to the actual costs of clinical labor, not the erroneous forecasts of them perpetuated on the ESRD PPS for years without remediation, which have placed significant financial pressure on providers and, in some cases, affected their ability to maintain dialysis capacity.

Finally, KCAPA would make important strides in advancing kidney disease detection and expanding Medicare's Kidney Disease Education (KDE) benefit, curbing system costs and extending the time before total kidney function fails and dialysis care, or transplant, is needed.

Conclusion

KCAPA gives individuals with ESRD and the providers that serve them an important pathway toward addressing a persistent public health challenge through meaningful reforms to an outdated and inflexible Medicare payment system that Congress has not materially attended to since 2008. By strengthening Medicare incentives to advance clinical innovations, ensuring MA plans follow them, ensuring payment accuracy under the ESRD PPS, and by improving access to kidney disease screening and education, KCAPA has the potential to dramatically improve life quality and experience for Medicare beneficiaries with ESRD and to advance the commitment Congress made in 1972 to this vulnerable population.

Statement for the Record

by the

Alliance for Home Dialysis

for the

United States House Committee on Energy and Commerce

Subcommittee on Health

**“Examining Legislative Proposals to Reform Medicare Provider Payment
and Bolster Health Care Cybersecurity”**

September 15, 2026

The Alliance for Home Dialysis thanks the House Committee on Energy and Commerce and its Subcommittee on Health for convening this hearing. We appreciate Chairman Brett Guthrie, Ranking Member Frank Pallone, Jr., Health Subcommittee Chairman Morgan Griffith, and Ranking Member Diana DeGette for considering legislation to improve care for Americans living with kidney disease and kidney failure.

The Alliance brings together individuals with kidney failure, clinicians, dialysis providers, and industry stakeholders to advance policies that expand access to home dialysis and protect patient choice. We welcome the Committee’s consideration of H.R. 8319, the KIDNEY Remote Monitoring Act, and H.R. 6214, the Kidney Care Access Protection Act.

About 815,000 Americans are living with kidney failure, and nearly 555,000 rely on dialysis. Peritoneal dialysis (PD) and home hemodialysis (HHD) can give patients greater control over their schedules and help them remain employed, pursue education, care for family members, and stay active in their communities. Too many people, however, never receive timely education or cannot access the clinical support and technology needed to begin and remain on home treatment. Congress can help address these barriers and provide the support needed for patients who want to receive treatment at home.

KIDNEY Remote Monitoring Act

The Alliance supports H.R. 8319, introduced by Representatives Rudy Yakym, Brad Schneider, Mariannette Miller-Meeks, and Debbie Dingell. This bipartisan legislation would permit separate reimbursement under the Medicare Physician Fee Schedule for remote physiologic monitoring furnished by physicians to patients with end-stage renal disease receiving home dialysis, beginning January 1, 2028. It would allow clinicians to receive payment for these services alongside the monthly capitated payment for dialysis-related physician services.

Remote monitoring can help clinicians identify problems earlier, keep patients connected to their care teams, reduce avoidable emergency care, and provide patients with greater confidence and support at home. Access to this support can be particularly valuable as patients adjust to home treatment or experience changes in their health. Medicare payment should support the ongoing clinical relationship and the work required to review monitoring information and respond to patient needs. We urge Congress to enact H.R. 8319 before the end of the 119th Congress.

Kidney Care Access Protection Act

We appreciate Representatives Carol Miller and Terri Sewell's work on H.R. 6214. Multiple important provisions align with the Alliance's priorities for expanded education, access to innovation, and adequate support for patient care, including:

- Extending Medicare kidney disease education eligibility to patients with stage 5 chronic kidney disease, broadening referral authority, and allowing qualifying dialysis facilities to furnish education with separate payment. The bill would also add chronic kidney disease screening to the Medicare annual wellness visit. These provisions can help patients better understand their treatment options and prepare for kidney failure. Education should present all appropriate options, including PD and HHD, and support shared decisions that reflect each patient's clinical needs and treatment goals.
- Revising Medicare's add-on payments for new dialysis drugs, equipment, and supplies and providing direct payments to providers for qualifying innovations used by Medicare Advantage enrollees. The Alliance supports payment pathways that help patients access technology and therapies that can improve their care. Implementation should remain patient-centered, clinically appropriate, and neutral between PD and HHD. Policies should account for how different home modalities use new technologies and avoid unintentionally favoring one modality over another.
- Adjusting dialysis payment updates to account for qualifying differences between forecast and actual price growth. The Alliance supports payment policies that reflect the true cost of delivering care, including the staff, equipment, and supplies needed to help patients begin and remain on home dialysis. Consistent with our congressional priorities, new services and technologies should receive adequate support without diverting resources from existing patient care. Expanding access should strengthen the capacity of care teams to serve patients.

No single modality is right for every patient. Lawmakers can help make patient choice more meaningful by ensuring that individuals have the education, support, technology, and continuity of care needed to select the treatment that best fits their clinical needs and their lives. These principles should guide the Committee's work on both kidney bills.

Congress has an opportunity before the end of the year to help more patients plan for treatment and receive the support they need to remain on their chosen modality. The Alliance thanks the Committee for considering these proposals and stands ready to work with members of both parties to strengthen patient choice and expand access to home dialysis.

Infectious Diseases Society of America
Statement for the Record
Energy and Commerce Committee, Health Subcommittee
Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care
Cybersecurity
September 15, 2026

Chairmen Guthrie and Griffith, Ranking Members Pallone and DeGette, the Infectious Diseases Society of America (IDSA) thanks you for holding a hearing on legislative proposals to reform Medicare provider payment, including the Patients First Act (H.R. 9693). As the Committee works to advance the Patients First Act, IDSA would welcome the opportunity to collaborate with you on targeted additions to the bill that would make meaningful progress toward addressing inadequate physician reimbursement and the resulting infectious diseases (ID) physician workforce shortages.

IDSA represents over 13,000 infectious diseases (ID) physicians and scientists across the country, and we are eager to work with you to address the ID physician workforce crisis that has been driven in large part by chronic underpayment. Infections account for billions of dollars in Medicare spending, and ID physician care reduces those costs by shortening hospitalizations, preventing readmissions and reducing unnecessary treatments. Unfortunately, far too few patients can access this lifesaving care. Nearly 80% of U.S. counties do not have an ID physician. In last year's annual Match, only 45% of ID physician training programs in the U.S. filled. We are facing a current and future severe shortage of ID physicians with devastating consequences for patients, including:

- Delays in accessing care, which lead to more serious infections that are more difficult and more costly to treat;
- Higher rates of hospital-associated infections and antimicrobial-resistant infections, as health systems do not have enough experts to effectively prevent and treat them; and
- Compromised, lower quality care for patients whose health procedures place them at greater risk for serious infections, such as patients receiving organ transplants, cancer chemotherapy, hip and knee replacements, and other surgeries.

These patient access challenges are particularly acute in rural and underserved areas. As our population ages and health care becomes increasingly complex and reliant on procedures and biologics that make patients more susceptible to infections, the need for ID physicians continues to grow.

ID is the third lowest paid medical specialty, below general internal medicine despite the additional two to three years of training. Unlike many other specialties, the work of ID physicians is not procedure-based, and we primarily bill inpatient evaluation and management (E/M) codes. Despite recent revaluation, these codes remain undervalued, and the reimbursement system has no way to appropriately account for the unique expertise that enables ID physicians to critically assess and solve complex medical problems that are foundational to the health care system.

These challenges have been exacerbated by a few key factors: The dearth of quality measures for our field severely limits the ability of ID physicians to participate in CMS quality programs and value-based alternative payment models (APMs), which in turn limits our ability to demonstrate our

specialty's value. Without relevant measures, ID physicians are systematically disadvantaged under the Merit-Based Incentive Payment System (MIPS) and excluded from Advanced APM participation pathways. ID physicians have very limited opportunities to participate in value-based payment models, in part because we are often consultants for patients receiving other care, such as organ transplants, cancer chemotherapy and complex surgeries. Current attribution methodologies and episode definitions frequently fail to account for the consultative and cross-cutting role of ID physicians.

In addition, recent cuts to practice expense reimbursement have disproportionately impacted ID physicians because about 75% of our physicians are facility-based and have experienced, on average, a 9% cut to our already low reimbursement. Because ID physicians care for some of the most medically complex and severely ill patients and also lead hospital programs for infection prevention, antimicrobial stewardship, and emergency preparedness and response, many ID physicians must be facility-based by the very nature of their work, which should not result in an inadvertent penalty.

IDSA would welcome the opportunity to collaborate with the sponsors of the Patients First Act and this Subcommittee on targeted additions to the bill that would make meaningful progress toward addressing inadequate ID physician reimbursement and the resulting ID physician workforce shortages. Our recommendations include:

- Directing the Quality Reform Task Force (proposed in Sec. 203, Patients First Act) to prioritize the recommendation of quality measures for medical specialties for which the Task Force determines that an inadequate set of quality measures exists.
- Directing CMS to include “specialties that are impacted by limited measure choice” in its existing annual report on progress made in quality measure development (Sec. 1848(s)(3), Social Security Act (SSA)).
- Renewing transfer funding to support quality measure development by extending the years authorized (Sec. 1848(s)(6), SSA).
- Adding “including specialties whose contributions toward quality improvement and cost efficiency are not meaningfully captured under existing value-based payment models, such as infectious diseases” to Sec. 303 of the Patients First Act provision calling for a report on barriers to participation in value-based payment models.
- Exempting non-procedural services from cuts to practice expense reimbursement that took effect in January 2026.

IDSA appreciates your consideration of these concerns and can provide draft legislative language for our recommendations. We stand ready to work with you to advance policies that ensure all Americans who could benefit from infectious diseases physician care have access to it.

Statement for the Record
by the
American College of Lifestyle Medicine
to the
House Committee on Energy and Commerce
Subcommittee on Health
“Examining Legislative Proposals to Reform Medicare Provider Payment
and Bolster Health Care Cybersecurity”
September 15, 2026

The American College of Lifestyle Medicine (ACLM) appreciates the opportunity to submit this statement to the House Committee on Energy and Commerce Subcommittee on Health, and applauds the committee’s leadership to advance meaningful reforms to physician payment. We urge Congress to advance Medicare payment reforms that support evidence-based chronic disease prevention and treatment, reward meaningful improvements in health, and give patients access to sustained, effective care over time.

ACLM is a medical professional association with over 17,000 members dedicated to advancing lifestyle medicine through education, clinical practice support, and advocacy. Our recommendations focus on three priorities relevant to the payment proposals before the Subcommittee.

Modernize Medicare payment to reward better health

ACLM supports the bipartisan direction of the Patients First Act of 2026 (H.R. 9693). Section 102 would establish a five-year hybrid primary care model with monthly payments replacing fee-for-service payment for designated services, including care management, behavioral health integration, office visits delivered in person or through telehealth, and patient communications. This approach could give clinicians greater flexibility to deliver coordinated, continuous care.

Payment reform should be judged by the health outcomes it rewards. Hybrid and prospective payments should support clinician-led interprofessional teams that deliver guideline-directed therapeutic lifestyle interventions. These models should reward prevention, sustained improvements in chronic disease, type 2 diabetes remission, and appropriate medication de-escalation when patients no longer need the same level of treatment. Congress should ensure that the primary care model explicitly supports lifestyle medicine, including individualized treatment plans and ongoing behavior-change support.

ACLM also supports the payment stability goals of the Provider Reimbursement Stability Act of 2026 (H.R. 8163). The bill would update the budget neutrality threshold, reconcile certain utilization estimates with actual experience, require periodic updates to direct practice expense inputs, and limit annual conversion factor changes caused by budget neutrality adjustments. Greater payment predictability would help practices plan investments in the staff and services needed for comprehensive chronic disease care.

Measure meaningful improvement in health

The Patients First Act provides a direct opportunity to better align quality measurement with meaningful patient outcomes. Section 202 would add a care efficiency category recognizing reductions in avoidable hospitalizations, chronic disease complications, and medication burden when clinically appropriate. Section 203 would establish a Quality Reform Task Force to recommend measures. ACLM supports these objectives and urges inclusion of lifestyle medicine expertise in the Task Force's work.

Federal quality measures should assess improved health outcomes rather than services provided. Further, they should measure outcomes that matter to patients, including fewer chronic disease complications, functional status, quality of life, and patient engagement. Quality measures must recognize evidence-based lifestyle interventions when they appropriately satisfy a measure's clinical objective, and avoid overweighting medication use.

The Medicare Physician Data-driven Performance Payment System Act of 2026 (H.R. 8622) would reform the Merit-based Incentive Payment System (MIPS) and strengthen requirements for timely performance feedback. As Congress considers this proposal alongside Patients First, ACLM urges lawmakers to use reliable measures that reward clinical improvement, provide actionable feedback, and account for patient complexity without discouraging successful treatment or adding unnecessary reporting burden.

The Access to Claims Data Act (H.R. 4331) would allow qualified and clinician-led clinical data registries to request Medicare claims data and link them with clinical outcomes for research and quality improvement. ACLM supports this objective. Connecting clinical results with utilization and spending data would help evaluate whether lifestyle medicine interventions improve health, reduce complications, and lower total costs. Implementation should preserve patient privacy and enable meaningful assessment of outcomes over time.

Equip the workforce to deliver lifestyle medicine

The primary care and quality reforms before the Subcommittee will depend on clinicians being prepared to deliver the care those policies seek to encourage. In the near future, the Committee should consider support for lifestyle medicine education (that includes nutrition education) throughout undergraduate, graduate, and continuing medical and health professional training.

Education should cover all six lifestyle medicine pillars, including nutrition, physical activity, sleep, stress management, connectedness, and avoidance of risky substances. Translating evidence into practice is a critical next step in achieving the Make America Healthy Again goals. ACLM offers curricula and educational resources that equip clinicians with evidence-based lifestyle intervention knowledge throughout every stage of their professional journey. Training should also prepare interprofessional teams to deliver shared medical appointments (SMAs),

support sustained behavior change, assess health outcomes, and adjust treatment safely as patients improve.

ACLM appreciates the Subcommittee's bipartisan work on Medicare payment reform and welcomes the opportunity to help develop policies that make evidence-based lifestyle medicine accessible to more patients.



**American College of Radiology
Statement for the Record**

**The U.S. House of Representatives
Energy & Commerce Health Subcommittee Hearing
on**

***“Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health
Care Cybersecurity”***

September 15, 2026

The American College of Radiology (ACR)—a professional association representing more than 40,000 physicians practicing diagnostic radiology, interventional radiology, radiation oncology, and nuclear medicine, as well as medical physicists, across the United States **strongly support** H.R. 9693, the Patients First Act, and greatly appreciates the Energy and Commerce Health Subcommittee discussing this urgently needed legislation.

The Patients First Act, bipartisan legislation introduced by E&C members Drs. Joyce, Murphy, and Schrier, seeks to improve and reform Medicare’s outdated physician payment program by:

- Creating an annual Medicare payment update tied to the Medical Economic Index, minus 1%, helping better account for inflation;
- Establishing the POINTS program, which creates a physician and clinician-led task force at CMS to develop quality metrics that are streamlined and reduce administrative burden, and;
- Adjusting Medicare budget-neutrality policies in the Medicare Physician Fee Schedule to help reduce significant payment fluctuations and support long-term payment reform.

The ACR would also like to praise the sponsors of the Patients First Act for their inclusion of Representative Harshbarger’s legislation, H.R. 5737, the Radiology Outpatient Ordering Transmissions (ROOT) Act. The ROOT Act amends the appropriate use criteria (AUC) program section of the Protecting Access to Medicare Act of 2014 (PAMA). Congress included the AUC program in PAMA to address the rising use of advanced diagnostic imaging in Medicare Part B and to encourage evidence-based ordering through clinical decision support.

The ROOT Act would modernize implementation of Medicare’s imaging AUC program and is a practical, bipartisan step toward realizing the original PAMA goals of advancing more appropriate imaging, reducing unnecessary utilization, and lowering costs for Medicare beneficiaries and the program alike. Furthermore, enacting the ROOT Act is projected to save approximately **\$2 billion for Medicare** and **\$1.5 billion for beneficiaries** over 10 years.

Providers would use AUC incorporated within clinical decision support tools to consult multi-specialty provider-developed, evidence-based guidelines at the point of care. Clinicians would maintain their clinical judgment and only need to document that they consulted the guidelines.

More than a decade after Congress acted to address inappropriate imaging and its downstream costs, patients and taxpayers are still waiting for the benefits of a fully operational AUC program. The ROOT Act would help unlock those benefits by improving appropriateness, increase health care affordability by reducing avoidable out-of-pocket costs, and supporting more efficient use of Medicare dollars.

Once again, the American College of Radiology appreciates your leadership to advance Medicare physician payment reform, as well as recognizing the need to reduce inappropriate medical imaging through physician-developed appropriate use criteria.

We look forward to working with you and your Congressional colleagues to achieve these goals. If you have any questions or would like more information, please contact [Dr. Dana Smetherman](#), MD, MPH, MBA, Chief Executive Office of the American College of Radiology.

**Statement
of the
American Hospital Association
for the
Committee on Energy and Commerce
Subcommittee on Health
of the
U.S. House of Representatives
“Examining Legislative Proposals to Reform Medicare Provider Payment and
Bolster Health Care Cybersecurity”
September 15, 2026**

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share the hospital field’s comments on legislative proposals that are to be considered before the Energy and Commerce Committee’s Subcommittee on Health on Sept. 15.

[H.R. 9693](#), Patients First Act of 2026; [H.R. 8163](#), Provider Reimbursement Stability Act of 2026

The Patients First Act of 2026 ties physician reimbursement to an inflation-based update of the Medicare Economic Index (MEI) -1%. The bill also establishes a primary care hybrid payment pilot program that pays primary care physicians a per-member-per-month (PMPM) payment. Additionally, the Patients First Act replaces the Merit-based



Incentive Payment System with the Patient Outcome Improvement National Tabulation System (POINTS) program, which creates a physician- and clinician-led task force at the Centers for Medicare & Medicaid Services (CMS) to develop quality metrics to streamline and reduce administrative burden. The bill freezes alternative payment model thresholds for three years.

Lastly, the Provider Reimbursement Stability Act of 2026 and Title IV of the Patients First Act both increase the budget neutrality threshold in the Medicare Physician Fee Schedule (up to \$54.3 million in the Provider Reimbursement Stability Act and up to \$57.64 million in Title IV of the Patients First Act).

AHA Response:

The AHA appreciates efforts to address the longstanding need for long-term physician payment reform and supports elements of these bills to increase the budget neutrality threshold under the physician fee schedule and to add an annual inflationary update to physician payment rates. Continued payment declines for physicians are unsustainable, particularly considering the physician shortages facing the country, and updates to the physician fee schedule conversion factor have not kept pace with inflation. We also support freezing the current alternative payment model participation thresholds to further advance value-based care adoption.

We would like to draw the committee's attention to a few provisions in the bills. The PMPM capitated payment demo in the Patients First Act is restricted to independent clinicians. Additionally, the POINTS bonus program is for high-performing independent practitioners only and creates limits on POINTS bonus payouts for non-independent providers at 50% of the total adjustment and redistributes the delta to independent providers.

We would encourage the committee to adjust the Patients First Act to allow for hospital and other provider-based clinicians to receive the full benefits of the PMPM capitated payment demo and the POINTS program bonus payouts. To fully achieve a more stable physician payment system and incentivize higher-quality care, all providers should be able to access these payments.

Lastly, we are concerned that an annual update based on the MEI -1% is not sufficient to account for the existing shortcomings in physician reimbursement. Medicare's physician fee schedule conversion factor, which determines physician payment, declined by 13% in real dollars from 2001 to 2026. The actual reduction in payments, when accounting for inflation, is a staggering 33%.¹ Therefore, we would urge the committee to use a higher update to physician reimbursement that more fully accounts for inflation.

¹ <https://www.ama-assn.org/system/files/2026-medicare-updates-inflation-chart.pdf>

H.R. 8622, Medicare Physician Data-driven Performance Payment System Act of 2026

This bill would replace the existing Merit-based Incentive Payment System (MIPS) with the Data-driven Performance Payment System (DPPS). The DPPS freezes the performance threshold at 75 points for three years to promote stability in MIPS. The Government Accountability Office (GAO) is commissioned to conduct a study on an alternative threshold methodology and offer recommendations to Congress and the Department of Health and Human Services (HHS). The bill also eliminates the current bonus and penalty payment adjustments in MIPS and links physician performance to annual payment updates. Additionally, the legislation requires CMS to provide quarterly performance feedback and protect clinicians from receiving negative adjustments if the agency does not deliver timely quarterly reports. The bill also provides additional incentive payments for smaller practices in rural and underserved areas to invest in care management and value-based care participation.

AHA Response:

The AHA appreciates this bill would replace MIPS with a similar system that we believe would preserve stability in physician payments and quality reporting while seeking additional refinements to how physician performance is assessed. In particular, we agree that it is necessary to prevent the performance threshold from rising without adequate evidentiary support and would value the opportunity to review findings from a GAO study and provide recommendations on behalf of our members and their clinical staff. In addition, we agree that quarterly feedback reports on measure performance would help clinicians improve their performance and appreciate that CMS would be held accountable for the timely provision of this data. Finally, we acknowledge the need for additional support for smaller practices, especially those in rural areas, to compete on a level playing field and, thus, would support additional incentive payments to these practitioners.

H.R. _____, Health Care Cybersecurity and Resiliency Act of 2026

This bill would require the Secretary of HHS and the Director of the Cybersecurity and Infrastructure Security Agency to coordinate to improve cybersecurity in the healthcare and public health sectors.

AHA Response:

We appreciate that the legislation would include grant funding opportunities to support adoption of cybersecurity best practices and appreciate the inclusion of provisions to bolster education and workforce training as well as cross-sector coordination. The AHA encourages the committee to provide further clarity on the applicability of cybersecurity standards to third-party vendors. Most protected health information (PHI) data breaches

reported to the Office of Civil Rights resulted from hacking incidents targeting non-hospital healthcare providers, including third-party service and software providers. One example is the Change Healthcare cyberattack, which resulted in the theft of 190 million Americans' PHI — the largest healthcare data breach in history. We believe third parties handling health information should be held to the same privacy and security standards as covered entities and business associates and encourage the committee to add a definition for third parties in Sections 2 and 8 of the legislation.

[H.R. 9908](#), Rural Hospital Cybersecurity Enhancement Act

The bill would direct HHS to create a comprehensive workforce strategy to train cybersecurity professionals and develop partnerships to expand the cybersecurity workforce for rural hospitals.

AHA Response:

The AHA supports this legislation, as it would give rural hospitals tools to strengthen cybersecurity and mitigate risks associated with harmful cyber threats.

[H.R. 1254](#), Rural Obstetrics Readiness Act

The bill seeks to improve obstetric emergency preparedness in rural healthcare settings, especially for those hospitals without dedicated obstetric units. The legislation focuses on training for practitioners in rural facilities that lack obstetric service units, establishes grant funding for rural obstetric readiness, creates a teleconsultation pilot program to support urgent maternal healthcare and directs HHS to study rural obstetric unit patterns and closures.

AHA Response:

The AHA supports this legislation, as it will help address maternal health needs in rural areas.

**Statement for the Record
by the
Primary Care Collaborative
for the
House Committee on Energy and Commerce
Subcommittee on Health
on
“Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster
Health Care Cybersecurity”**

September 15, 2026

Thank you for the opportunity to submit this statement on behalf of the Primary Care Collaborative (PCC) regarding the first item on the agenda: H.R. 9693, the Patients First Act of 2026.

The PCC is a nonprofit, nonpartisan coalition of 66 organizational members, including clinicians, patient advocates, employer groups, and health plans. The PCC and its members are dedicated to a high-quality health care system rooted in whole-person primary care, with a focus on comprehensive, ongoing relationships and addressing underlying factors to improve patient experience and health outcomes. The PCC launched the Better Health Now campaign in 2022 as a broad-based effort led by diverse PCC members to enact federal policy changes that will improve Americans’ health by expanding access to primary care.

PCC and our Better Health NOW Campaign have expressed our support for the Patients First Act. The PCC appreciates the bipartisan leadership reflected in the legislation and supports the legislation's efforts to modernize Medicare physician payment, strengthen patient access to care, and provide greater stability and flexibility for primary care practices. We believe these reforms are important steps toward a Medicare payment system that better recognizes the value of primary care, care coordination, prevention, behavioral health integration, and other high-value services that patients need. This statement focuses on the hybrid primary care payment model detailed in section 102 of HR 9693, articulates its importance to the nation’s health and **offers specific recommendations to strengthen the bill as it moves through the legislative process.**

Primary Care as the Foundation of the Health Care System

Research has consistently demonstrated that primary care is the foundation of an effective health care system. Primary care clinicians are often the first point of contact for patients and serve as trusted partners in prevention, chronic disease management, care coordination, and

navigation across the health care system. Strong primary care is associated with better health outcomes, lower mortality, and greater life expectancy at similar or lower total costs.ⁱ

Yet the United States continues to underinvest in primary care. Primary care accounted for only approximately 4.5 percent of total U.S. health care spending in 2023, down from 5.4 percent in 2012.ⁱⁱ This longstanding underinvestment has consequences for patients and clinicians alike, contributing to workforce challenges, limited access, and growing pressure on primary care practices to provide more comprehensive services with insufficient resources.

The problem is particularly acute for practices whose patient panels have complex health and social needs, requiring management over time to prevent avoidable complications. Primary care clinicians frequently coordinate among specialists, hospitals, pharmacies, behavioral health providers, community-based organizations, and other services. Medicare payment policy should recognize and support this work.

Modernizing Medicare through Hybrid Payment

For decades, fee-for-service payment has placed primary care at a structural disadvantage by emphasizing individual discrete services, rather than the relationships and team-based care that are central to comprehensive primary care. We are grateful that Congressional leaders have recognized that building on the current fee-for-service system will not advance the structural reforms necessary to improve the health of the nation. H.R. 9693 takes important steps toward addressing these longstanding shortcomings.

The legislation would establish a five-year demonstration creating a hybrid payment approach for eligible primary care clinicians, combining traditional fee-for-service payments with prospective per-member-per-month payments. **This approach has significant potential to provide primary care practices with the predictable resources necessary to invest in care teams, care management, behavioral health integration, technology, and other infrastructure that supports comprehensive, patient-centered care.** The model as designed includes critical provisions to ‘except budget neutrality’ as in, letting the payments for model services proceed outside of the restrictions of budget neutrality, for the years of the model, both preserving the principles of the model as independently evaluable, and avoiding the evitable external conflicts that arise within the confines of a budget neutral construct.

The PCC has long championed hybrid payment for primary care because it provides practices with greater predictability, sustainability, and flexibility to best meet patient needs. Practices can craft a high-quality team-based approach for the patient, that treats the whole person and their needs, while at the same time preserving appropriate fee-for-service

payments for services that should be incented or are not regularly delivered across primary care practices.

Tests of prospective payments have proven that predictable up-front payments allow practices to build capacity, add talent to teams, and improve the quality of care. The Centers for Medicare and Medicaid Services (CMS) has tested and repeatedly leveraged up-front investments at the Innovation Center (CMMI) with nearly all models receiving infrastructure or pre-implementation funding, and a number of model designs including recurring prospective payments (i.e., ACO REACH, PC Flex, Primary Care First, Advance Payment ACO, ACO Investment, CHART, MCP, AHEAD, LEAD, KCC, Maryland Primary Care, Vermont All-Payer ACO, etc.).ⁱⁱⁱ

The Patients First Act's primary care provisions recognize that some of the most important primary care services cannot be adequately supported through traditional fee-for-service billing. **Care management, behavioral health integration, patient outreach, follow-up communications, and other activities that provide continuity and longitudinal care to help patients remain healthy and avoid unnecessary utilization often require time and resources that are not captured accurately by individual encounters.** Without access to prospective payments, practices find it more difficult to plan, invest, recruit and retain clinicians, and maintain access to care. Independent and community-based practices and those providing safety net care are disproportionately impacted when payment does not adequately reflect the cost and value of delivering primary care.

By providing prospective funding for hybrid model activities, the demonstration could give primary care practices greater capacity to deliver whole-person care and develop the primary care teams that patients and communities deserve.

Hybrid Model Eligibility for Success

While the PCC supports the proposed hybrid payment demonstration, **we believe the legislation should be carefully structured to ensure that it generates meaningful evidence about how prospective primary care payment can improve outcomes for diverse Medicare populations.**

As currently drafted, eligibility limitations could prevent participation from practices serving patients in academic medical centers, community health centers, other safety-net settings, and independent primary care practices that participate in ACOs or clinically integrated networks that engage with private payers. As a result, **the narrowly drawn eligibility limitations could effectively exclude some of the more complex Medicare beneficiaries, including beneficiaries who are dually eligible for Medicare and Medicaid.** The most complex Medicare beneficiaries often have the greatest need for coordinated, longitudinal primary care.

They may require behavioral health services, social supports, specialty care, medication management, and coordination across multiple settings.

These patients and practices should not be left out of a demonstration because any future application of this payment methodology would benefit from a test that includes a cross-section of patient populations and practice types. Similarly, independent practices that participate in accountable care organizations or other value-based arrangements should not inadvertently be excluded simply because of their organizational structure.

The PCC encourages Congress and CMS to examine these eligibility provisions carefully as the legislation advances. A successful hybrid model demonstration should serve and generate evidence across a broad range of patients and practice settings, including those serving rural, underserved, medically complex, and historically under-served populations.

Eliminating Cost-Sharing in the Hybrid Model

The PCC also supports the bill's elimination of beneficiary cost sharing in the hybrid model. Cost-sharing creates unnecessary barriers to high-value care. Patients may delay or forgo preventive services, care management, behavioral health services, or follow-up care when they face out-of-pocket costs, even when those services can help prevent more serious and expensive health problems later. The Patients First Act would address this barrier within the proposed primary care demonstration by waiving beneficiary cost-sharing for covered services included in the per-member-per-month bundle.

Reducing financial barriers to care shifts Medicare toward a system that invests in upstream prevention rather than waiting until patients require more intensive and costly intervention – providing excellent government ROI.^{iv} Eliminating the barrier of cost sharing is particularly important for care management and integrated behavioral health services. These services help patients manage chronic conditions, address mental health and substance use disorder needs, coordinate care across settings, and intervene earlier when health problems arise.

As the PCC shared in a Statement for the Record for the House Committee on Energy and Commerce Subcommittee on Health May 20, 2026, hearing *Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reform*, **cost-sharing creates unnecessary challenges for clinicians and patients – causing administrative friction and placing needless financial burdens on accessing high-value primary and preventive care.**^v

Strengthening Behavioral Health Integration

Behavioral health integration is another important component of comprehensive primary care and an area where the legislation could be further strengthened. Primary care clinicians

routinely identify and address behavioral health needs, and connect patients to other behavioral health professionals, yet this whole-person approach may not fit neatly within traditional fee-for-service payment structures.

The proposed hybrid model creates an opportunity to support greater integration of behavioral health into primary care, but the legislation as drafted lacks information on services included within the prospective payment bundle, and outside the bundle. **Whether in future drafts, report language, or agency guidance, further clarification of behavioral health services included in the model should be provided, with assurance that payment for services outside the bundle remain separately and appropriately billable.**

A well-designed demonstration will yield the strongest test results, and help primary care practices build integrated teams and make behavioral health services more accessible while recognizing the full value of services that require specialized expertise.

The Congressional Responsibility to Invest in Primary Care

Investments to strengthen primary care should be seen not as expenditures, but as opportunities for short and long term gains in financial savings for Americans, better quality of health services, and improved future health outcomes for patients. Evidence from Medicare and accountable care models has found that organizations with stronger primary care capacity generate larger savings and improve care more effectively.^{vi} By avoiding preventable hospitalizations, managing chronic conditions, coordinating follow-ups, and providing whole-person services in lower-cost community settings, primary care practices are a practical and logical investment. As the Medicare program confronts long-term spending pressures, Congress and official actuarial scoring of this legislation should factor in the downstream consequences of inadequate investment in primary care and potential for future savings with proper investment.

Quality Reform Task Force Representation

While the Quality Reform Task Force represents an effort to improve and standardize measures, the PCC believes that patient perspectives should be represented in this process. As a multistakeholder organization, the PCC has seen the value of bringing patients, clinicians, employers, health plans, and other stakeholders together to develop policies that reflect the realities of the health care system. Patient representation on the Quality Reform Task Force would strengthen the process and help ensure that quality measurement remains focused on what matters most to the people receiving care.

Recommendations

The PCC respectfully recommends that Congress focus make the following three improvements to the Patients First Act:

1. **Clarify the eligibility for the hybrid model to ensure that model eligibility does not focus on the largest or most highly resourced organizations.** Eligibility and implementation should allow independent practices and other safety net providers to participate meaningfully, including practices that participate in accountable care organizations.
2. **Increase specificity in the bill or subsequent materials around behavioral health services to be included in the hybrid model and those to remain separately billable outside of the PMPM at their full value.**
3. **Add patient representation to the Quality Reform Task Force to ensure meaningful representation** and improved measurements that reflect outcomes and experiences that matter to beneficiaries.

Conclusion

The United States cannot achieve a high-value, patient-centered health care system that cares for a whole person and provides longitudinal and high-quality care, without a strong foundation of primary and preventive care. Primary care clinicians are the backbone of prevention, chronic disease management, care coordination, behavioral health integration, and continuous care relationships that keep our country healthy. Yet Medicare pricing has historically undervalued these activities with inadequate investment in teams and infrastructure required to deliver comprehensive care. **H.R. 9693 the Patients First Act of 2026 represents an important step toward stronger primary care and better health for American families and communities.**

The PCC especially supports Congress' efforts to establish a hybrid primary care payment model, reduce cost-sharing barriers to high-value services, provide budget neutrality, modernize quality measurement, and address longstanding structural problems in Medicare payment. At the same time, legislators have **an opportunity to strengthen the legislation by ensuring that the hybrid model reaches complex and underserved beneficiaries, that independent and community-based practices can participate, that behavioral health integration is appropriately supported, and that patients have a meaningful voice in quality reform.**

The PCC and its 66 member organizations stand ready to work with Congress, CBO and CMS to advance policies that strengthen primary care, improve access and outcomes for Medicare beneficiaries, and support a high-value health care system.

Thank you for including our perspective in the record. Any questions may be directed to Senior Director of the Better Health NOW campaign – Katie Comando at kcomando@thepcc.org

ⁱ Centers for Medicare & Medicaid Services, “The CMS Innovation Center’s Strategy to Support High-Quality Primary Care,” June 9, 2023.

^{ii 4} Primary Care Collaborative. (2025). Make Medicare Beneficiaries Healthier by Strengthening Primary Care. <https://thepcc.org/wp-content/uploads/2025/03/Make-Medicare-Beneficiaries-Healthier-Issue-Brief.pdf>

ⁱⁱⁱ Centers for Medicare & Medicaid Services (CMS), <https://www.cms.gov/priorities/innovation/about>

^{iv} Pollack, A. A., Ricci, D. A., Song, Z., Sullivan, E. E., Grumbach, K., Cohen, D. J., Phillips, R. S., & Primary Care Collaborative. (2025). *The Primary Care Investment Guide*.

^v U.S. Congress, House Committee on Energy and Commerce Subcommittee on Health, Ann Greiner, Statement for the Record, 119th Cong., 2nd session, 2026, vol. 172, No.86, page:D540.

<https://thepcc.org/wp-content/uploads/2026/05/PCC-SFTR-5.20.26-EC-MACRA-hearing-FINAL.pdf>

^{vi} Gao J, et al., “The Effect of Primary Care Visits on Total Patient Care Cost,” *Journal of General Internal Medicine* (2022).

September 15, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
2323 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Griffith and Ranking Member DeGette,

CVS Health commends you for including H.R. 3164, *The Ensuring Community Access to Pharmacist Services Act*, in today's hearing on "Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity." This legislation will ensure that America's seniors have access to essential pharmacist services, including testing and treatment for common respiratory conditions, in alignment with state scope of practice laws.

As a leading health solutions company, CVS Health helps people navigate the health care system — and their personal health care — by improving access, lowering costs and being a trusted partner for every meaningful moment of health. Every day at more than 9,000 neighborhood pharmacy locations, our pharmacists provide unmatched high-quality, personalized, affordable health care to more than 100 million patients and customers.

Pharmacists are the most accessible health care professionals in the country. Nearly nine in ten Americans live within five miles of a pharmacy, and around 85% of Americans live within ten miles of a CVS Pharmacy. Americans visit their neighborhood pharmacist about twice as frequently as they visit their physician or other qualified health care professional. Access to pharmacist services is particularly important for Americans living in rural communities or medically underserved areas where a pharmacist may be the only health care provider in the community.

The *Ensuring Community Access to Pharmacist Services Act* represents a critical step forward in ensuring access to these essential providers. Operating within state laws, this bipartisan bill would ensure that seniors can access essential testing and



1275 Pennsylvania Ave NW, Suite 700

Washington, D.C., 20004

treatments for influenza, RSV, and other common infectious diseases from their pharmacist. We urge the Committee to advance and Congress to enact this legislation as soon as possible.

Thank you again for including this legislation in today's Committee proceedings.

Sincerely,

A handwritten signature in black ink that reads "Melissa Schulman". The signature is fluid and cursive, with the first name "Melissa" and last name "Schulman" clearly legible.

Melissa Schulman
Senior Vice President, Government & Public Affairs
CVS Health

Statement for the Record

Committee on Energy and Commerce – Subcommittee on Health
Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care
Cybersecurity

Tuesday, September 15, 2026, 10:30 AM ET

The Future of Pharmacy Care Coalition (FPCC) submits the following Statement for the Record in response to the Committee on Energy and Commerce – Subcommittee on Health’s hearing entitled *Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity*.

FPCC applauds the Subcommittee for considering H.R. 3164, the *Main Street Pharmacy Access Act* during the hearing. We applaud the Subcommittee for recognizing the critical role pharmacists play in care delivery and for advancing legislation to help ensure that America’s seniors have the same access as other beneficiaries to essential pharmacist services, including testing and treatment for common respiratory conditions, in alignment with state scope of practice laws. We are proud to note that the bill has broad bipartisan support among Committee members, with 20 Republican and 18 Democratic cosponsors.

FPCC includes American healthcare companies and professional associations that together provide care for hundreds of millions of patients across communities and represent pharmacists and pharmacies of all sizes across the United States. FPCC advocates for federal policy solutions that recognize and advance the critical role pharmacists play in caring for patients and ensure they can continue to create a more just and sustainable healthcare system.

Pharmacists are the most accessible health care provider and play a frontline role in delivering prompt services to seniors, including those living in rural areas and other vulnerable communities, to protect them from common infectious diseases. Nine in 10 Americans live within five miles of a pharmacy,¹ and patients visit their community pharmacist approximately twice as frequently as they visit primary care physicians.² In areas with provider shortages where individuals have limited access to healthcare resources, notably rural areas, pharmacists bridge access gaps to deliver testing, treatment, and other routine services. Medicare patients in rural areas make an average of 14 pharmacy visits per year, compared to just 5 visits to primary care physicians. Further, older Americans are among the most vulnerable to respiratory illnesses, such as the flu and RSV, underlining the importance of immediate access to pharmacist services for this at-risk demographic. Given their accessible nature, pharmacists provided 64 percent of adult doses of influenza vaccines during the 2024-2025 flu season,³ and during the last pandemic, pharmacists delivered more than 350 million clinical interventions, including over 42 million COVID-19 tests and more than 100,000 antibody treatments.

Despite the accessible and valuable nature of these services, Medicare does not reimburse pharmacists for testing and treatment services. The *Main Street Pharmacy Access Act* corrects that gap by providing Medicare Part B reimbursement mechanisms for pharmacist-administered testing and treatment of common respiratory illnesses, including influenza, COVID-19, and RSV as well as strep throat. The services covered in the legislation would be limited to state scope of practice or provided incident to a physician’s

¹ Lucas A. Berenbrok, et al., *Access to community pharmacies: A nationwide geographic information systems cross-sectional analysis*, 62 J. Am. Pharmacists Assoc. P1816 (2022), [https://www.iaapha.org/article/S1544-3191\(22\)00233-3/fulltext](https://www.iaapha.org/article/S1544-3191(22)00233-3/fulltext).

² Samantha Valliant, et al., *Pharmacists as accessible health care providers: quantifying the opportunity*, 28 J. Managed Care and Specialty Pharm. 85 (Jan. 2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8890748/>.

³ *Influenza Vaccinations Administered in Pharmacies and Physician Medical Offices, Adults, United States*, Ctrs. for Disease Control and Prevention (May 7, 2025), <https://www.cdc.gov/fluview/dashboards/adult-vaccinations-administered.html>.

service. The bill would help address the economic burden that pharmacies face, enabling them to continue providing the crucial community healthcare that seniors rely on. Given the importance of this legislation, we thank the Subcommittee for advancing the *Main Street Pharmacy Access Act* and urge Congress to enact it as soon as possible.

Thank you for the opportunity to provide this Statement for the Record. Please do not hesitate to reach out to Bob Siggins at bob.siggins@alston.com with any questions or concerns.

*

*

*

The Future of Pharmacy Care Coalition is a group representing pharmacists and community pharmacies of all sizes serving millions of patients daily across the United States. Coalition members supporting the legislation include:

Abbott Laboratories
American Pharmacists Association (APhA)
American Society of Health-System Pharmacists (ASHP)
Cardinal Health
Cencora, Inc.
CVS Health
Good Neighbor Pharmacy
Health Mart
Kroger
McKesson Corporation
The Medicine Shoppe Pharmacy
National Association of Chain Drug Stores (NACDS)
National Community Pharmacists Association (NCPA)
Walgreens
Walmart
XiFin, Inc.

September 14, 2026

The Honorable Brett Guthrie
Chairman
House Committee on Energy and Commerce

The Honorable Morgan Griffith
Chairman
Health Subcommittee
House Committee on Energy and Commerce

The Honorable Frank Pallone
Ranking Member
House Committee on Energy and Commerce

The Honorable Dianna DeGette
Ranking Member
Health Subcommittee
House Committee on Energy and Commerce

RE: September 15, 2026, Subcommittee on Health Hearing *Examining Legislative Proposals to Reform Medicare provider Payment and Bolster Health Care Cybersecurity*

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Griffith and Ranking Member DeGette,

The American Association of Nurse Practitioners (AANP), representing the 461,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide a statement for the record for the House Energy and Commerce Committee Subcommittee on Health legislative hearing entitled *Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity*. The committee's attention to outdated Medicare provisions which inhibit patient access to care is an essential component of addressing challenges in payment reform for all health care providers. We look forward to continuing to work with the Committee on strengthening the Medicare program for patients and health care providers. In particular, we appreciate the Committee placing both **H.R. 1616 the *Promoting Access to Diabetic Shoes Act*** and **H.R. 9693, the *Patients First Act of 2026*** on the agenda, and we look forward to seeing both bills advance to the full Committee.

As you know, NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds. Daily practice includes assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.) and perform nearly one billion patient visits annually. Currently, twenty-seven states, the District of Columbia and two U.S. territories have adopted full practice authority (FPA), granting patients full and direct access to nurse practitioners.

NPs practice in nearly every geographic region and health care setting including hospitals, clinics, Veterans Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs) and nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and provide the most home-based care to Medicare beneficiaries.

NPs provide a substantial portion of the high-quality¹, cost-effective² care that our communities require. According to the Centers for Medicare and Medicaid Services (CMS), as of 2024, there were over 243,000 NPs billing for Medicare services, making NPs the largest Medicare designated provider specialty,³ and approximately 80% of NPs are seeing Medicare and Medicaid patients.⁴ NPs have a particularly large impact on primary care as approximately 70% of all NP graduates are prepared in primary care.⁵

According to the Medicare Payment Advisory Commission (MedPAC), APRNs and physician assistants (PAs) comprise approximately one-third of our primary care workforce, and up to half in rural areas.⁶ As stated in MedPAC's July 2025 data book, Medicare "encounters with APRNs and PAs grew rapidly from 2018 to 2023 (50 percent in total), and encounters with primary care physicians declined substantially (– 22 percent)."⁷ Further, the Commission highlights that these changes "continue a longer-term trend of declines in services billed by primary care physicians and rapid increases in the number of services billed by APRNs and PAs."⁸ Fifty-seven percent of Medicare beneficiaries received a primary care service from an NP or PA, and sixty-six percent of rural Medicare patients received a primary care service from an NP or PA.⁹

As NPs continue to provide increasing amounts of care for Medicare patients, it is important to understand the significant evolution of the role of NPs in Medicare. In 1977, Congress first formally recognized care delivered by nurse practitioners in the Medicare program in rural health clinics.¹⁰ In 1989, Congress authorized direct reimbursement under the Medicare program for services rendered by nurse practitioners in rural areas, and indirect reimbursement for NPs rendering services in skilled nursing facilities.¹¹ Importantly, since 1997, Congress has authorized reimbursement under the Medicare program to NPs regardless of setting or geographic area, for any services that would be covered when provided by a physician, in accordance with State law, at 85% of the fee schedule rates.¹² Despite the increasing amount of care NPs provide for Medicare patients, structural barriers remain within the Medicare program which restrict NPs' authority to provide care in their communities. In light of the challenges facing health care, it is critical that Medicare's payment policies are updated to reflect the modern delivery of health care.

Overly restrictive Medicare statutes lead to many of the issues identified by the Chairmen in their announcement, including limited access to care and restricted options for patients. These factors cost patients time in their care journey, cost Medicare money, and lead to an inefficient health care system which cannot proactively address chronic care to prevent and treat disease.

Removing barriers on NPs and their patients has been a policy objective over multiple Presidential Administrations. Section 5 of Executive Order 13890 on *Protecting and Improving Medicare for Our Nation's Seniors*, called for removing burdensome requirements in the Medicare program that are "more stringent than applicable Federal or State laws require and that limit professionals from practicing at the

¹ <https://www.aanp.org/images/documents/publications/qualityofpractice.pdf>.

² <https://www.aanp.org/images/documents/publications/costeffectiveness.pdf>.

³ <https://www.cms.gov/files/zip/cy-2026-pfs-proposed-rule-specialty-impacts-practitioner.zip>

⁴ https://storage.aanp.org/www/documents/NP_Infographic.pdf

⁵ Ibid

⁶ https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2.)

⁷ July 2025 Data Book: Health Care Spending and the Medicare Program – MedPAC

⁸ Ibid

⁹ Ibid

¹⁰ [STATUTE-91-Pg1485.pdf \(govinfo.gov\)](#)

¹¹ [STATUTE-103-Pg2106.pdf \(govinfo.gov\)](#)

¹² [63 FR 30862](#)

top of their profession.¹³ Additionally, the *Reforming America's Healthcare System Through Choice and Competition* report from the Department of Health and Human Services, the Department of Treasury, and the Department of Labor¹⁴ called for removing barriers to care for clinicians, and highlighted the anticompetitive impacts of restrictive policies. The 2018 Centers for Medicare and Medicaid Services (CMS) Rural Health Strategy Report also identified authorizing NPs to practice to the top of their license as a key supporting activity, which was also reflected in the Rural Health Transformation Program¹⁵.¹⁶ In 2024, the Substance Abuse and Mental Health Services Administration (SAMHSA) updated its rule for Opioid Treatment Programs, recognizing the importance of removing barriers to care provided by NPs.¹⁷

As shown within these examples, when policies are updated to better reflect the care provided by nurse practitioners, access to care is improved. Therefore, we strongly agree with the aims of this hearing and encourage the full Committee to take favorable action on two pieces of legislation on its agenda today: **H.R. 1616 the *Promoting Access to Diabetic Shoes Act*** and **H.R. 9693, the *Patients First Act of 2026***.

H.R. 1616 Promoting Access to Diabetic Shoes Act

H.R. 1616 will authorize NPs and physician associates/physician assistants (PAs) to certify when their patients with diabetes meet the clinical criteria to qualify for therapeutic shoes, so that they can promptly be seen by a podiatrist to be fit and furnished for this critical intervention. Due to statutory restrictions, their patients with diabetes must undergo the following multistep process to obtain medically necessary therapeutic shoes under Medicare. First, when the treating NP/PA determines that the patient has a condition requiring therapeutic shoes, the NP/PA must send the patient to a physician to make the same determination and to take over the patient's care related to diabetes. Then the physician refers that patient to a "podiatrist or other qualified individual" to fit and furnish the shoes. This process not only forces a patient to change providers, but it delays patient access to effective treatment for complications related to diabetes.

For patients facing transportation challenges, and especially those in rural communities, requiring an additional medical appointment to receive a certification is a challenge. Additionally, there is not always a certifying physician readily available, resulting in delays in timely and necessary care. Early intervention involving therapeutic shoes has been shown to reduce ulcerations and resulting complications, improve quality of life, and reduce health care spending. According to the American Diabetes Association, therapeutic shoes are a recommended therapy for people with diabetes at high risk for ulceration.¹⁸

NPs play an important role in managing and delivering high-quality, cost-effective health care to their patients. They have expert knowledge that allows them to provide high-level assessments of patient needs, with a focus on disease prevention and health promotion. NPs are particularly skilled in the management of diabetes, as evidenced by multiple studies supported by the Veterans Health Administration (VA) which found that nurse practitioner management of patients with diabetes lowered health care costs due to fewer readmissions and emergency department visits.¹⁹

¹³ [Executive Order on Protecting and Improving Medicare for Our Nation's Seniors – The White House](#)

¹⁴ [Reforming America's Healthcare System Through Choice and Competition](#)

¹⁵ [Rural Health Transformation Program](#)

¹⁶ <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf>, at pages 4-5.

¹⁷ [Federal Register :: Medications for the Treatment of Opioid Use Disorder](#)

¹⁸ https://diabetesjournals.org/care/article/47/Supplement_1/S231/153941/12-Retinopathy-Neuropathy-and-Foot-Care-Standards. See recommendation 12.31.

¹⁹ Rajan, S.S., Akeroyd, J.M., Ahmed, S.T., Ramsey, D.J., Ballantyne, C.M., Petersen, L.A. & Virani,

Passage of H.R. 1616 will authorize NPs to continue providing high-quality care for their Medicare patients with diabetes. Given NPs' proven track record for the care of patients with diabetes and being recognized as Part B Medicare providers who can order and refer for DME, now is the time to modernize the Medicare program to authorize NPs to certify this cost-saving and clinically effective care. It will also reduce Medicare spending by eliminating duplicative services, improving the timeliness of care for patients with diabetes who need therapeutic shoes and allowing patients to continue receiving care from their provider of choice. This bill would not change the information that needs to be documented, a podiatrist will still be required to fit for the shoes, and it would better align Medicare policy with state law. The only change made by this bipartisan legislation is that NPs and PAs would be authorized along with physicians to certify their patient's need for therapeutic shoes. This change would have a major positive impact on patients by allowing NPs to retain the care of patients, and ensuring patients are able to receive timely referrals.

It is important to understand the evolution of the role of NPs in Medicare, and how this aligned with the development of the diabetic shoes benefit. In 1977, Congress first formally recognized care delivered by NPs in the Medicare program in rural health clinics, and at this time they had not yet been authorized to order durable medical equipment (DME) for Medicare patients, or bill for Medicare Part B services.²⁰ Three years later, under the Omnibus Budget Reconciliation Act (OBRA) of 1980, Congress mandated a comprehensive study of methods for providing coverage of therapeutic shoes under Medicare Part B, and recommendations regarding coverage. HHS submitted this report in 1981. Coverage of therapeutic diabetic shoes as a demonstration project was established in OBRA of 1987 to determine the cost-effectiveness of the coverage.

OBRA of 1989 expanded the demonstration benefit to allow for additional inserts. HHS was required to submit certain reports on cost effectiveness to Congress for the demonstration to continue through 1992 and subsequently 1993. The initial report recommended the continuance of the demonstration project, and on May 1, 1993, coverage became a Medicare benefit. Importantly, this was established prior to Congress fully authorizing NPs as Medicare providers.

It was not until OBRA of 1997 when NPs were authorized to be reimbursed under the Medicare program regardless of setting or geographic area, for any services that would be covered when provided by a physician, in accordance with State law, at 85% of the fee schedule rates.²¹ This included the authorization for NPs to order DME. However, due to the statutory structure of the therapeutic shoe program from 1987, including the division of therapeutic diabetic shoes as a separate program outside of DME, the recognition of NPs as Medicare providers under the OBRA of 1997 did not include diabetic shoes.

The Center for Medicare and Medicaid Innovation (CMMI) has also recognized the benefits of removing this barrier in multiple demonstration models including: Primary Care First, ACO REACH, and GPDC.²² In these models, the agency utilized its statutory authority to authorize NPs to certify a patient's need for therapeutic shoes, stating the policy change is "expected to reduce delays in patients accessing this benefit and avoid the costs of an additional clinician visit."²³ Additionally, within the U.S. Department of Veterans Affairs (VA), NPs are authorized as prescribing clinicians for the provision of therapeutic

S.S. (2021). Health care costs associated with primary care physicians versus nurse practitioners and physician assistants. *Journal of the American Association of Nurse Practitioners*, 33(11), 967-974. <https://pubmed.ncbi.nlm.nih.gov/34074952/>

²⁰ [STATUTE-91-Pg1485.pdf \(govinfo.gov\)](#)

²¹ [63 FR 30862](#)

²² [Global and Professional Direct Contracting \(GPDC\) Model | CMS](#)

²³ [ACO Realizing Equity, Access, and Community Health \(REACH\) Model Request for Application](#)

footwear and in-shoe orthoses based on disease, foot/ankle deformity and circumstances not covered by deformity/disease.²⁴

Most recently, the Long-Term Enhanced ACO Design (LEAD) Model recognized the impact of this barrier on the Medicare program. Utilizing statutory flexibilities to test CMMI models, LEAD authorizes NPs and PAs to certify their patients' need for therapeutic diabetic shoes. CMMI states that removal of this barrier is "is expected to reduce delays in patients accessing this benefit and avoid the costs of an additional clinician visit."²⁵ CMMI states that waiving this barrier is expected to "limit Medicare expenditures by providing a streamlined approach for certifying and ordering care, avoiding duplicative work."²⁶ The agency notes that empowering NPs "would capitalize on established relationships between a beneficiary and a NP to reduce impediments to better coordinate care for beneficiaries and bridge potential gaps in coverage."²⁷ However, H.R. 1616 is necessary to remove this barrier outside of demonstration models. Below is data which shows the impact that complications from diabetes have on patients and the Medicare program.

Supporting Data for H.R. 1616

- More than 1 in 4 (26%) Medicare beneficiaries have diabetes.²⁸
- Up to one-third of the costs of diabetes care are for diabetic foot ulcers and other lower-extremity complications.²⁹
- Lower Limb Amputations (LLAs) are increasing. The number of diabetes-related hospitalizations due to LLAs doubled from 2009-2019.³⁰
- 87% of LLAs are a result of complications from diabetes. The proportion of LLAs attributable to diabetes is highest for people ages 45-74.³¹
- Utilization of therapeutic footwear is effective for the prevention of DFU in at-risk patients with diabetes.^{32, 33}
- It is well accepted clinically that optimal footwear, which includes extra-depth shoes, custom foot orthoses, and biomechanically appropriate shoe modifications, is an essential element in the treatment of foot ulcers and in the prevention of reulceration of the high-risk diabetic foot.³⁴
- Expanded access to nurse practitioners is associated with fewer foot debridement and foot ulcer complications for patients in rural counties.³⁵

H.R. 9693, the *Patients First Act of 2026*

AANP also thanks the Committee for including H.R. 9693 in this subcommittee hearing. We agree with the importance of improving Medicare's current reimbursement model which does not reflect the modern

²⁴ VHA Directive 1173.9(1)

²⁵ [lead-rfa.pdf](#)

²⁶ Ibid

²⁷ Ibid

²⁸ Chronic Condition Data Warehouse. (2024). CCW Web Chart: Medicare – CCW Condition Period Prevalence, 2022.

<https://www.ccdwdata.org/web/guest/medicare-charts/medicare-chronic-condition-charts>

²⁹ Armstrong, D.G., Swerdlow, M.A., Conte, M.S., Padula, W.V. & Bus, S.A. (2020). Five year mortality and direct costs of care for people with diabetic foot complications are comparable to cancer. *Journal of Foot and Ankle Research*, 13(16). <https://doi.org/10.1186/s13047-020-00383-2>

³⁰ CDC. (2024). [Preventing Diabetes-Related Amputations | Diabetes | CDC](#)

³¹ CDC. (2021). Diabetes State Burden Toolkit. <https://nccd.cdc.gov/Toolkit/DiabetesBurden/Hospitalization/Lea>

³² Bus, S.A., van Netten, J.J., Lavery, L.A., Monteiro-Soares, M., Rasmussen, A. & Jubiz, Y., Price, P.E. (2016). IWGDF guidance on the prevention of foot ulcers in at-risk patients with diabetes. *Diabetes/Metabolism Research and Reviews*, 32(Suppl.1), 16-24. doi: 10.1002/dmrr.2696

³³ American Diabetes Association. (2018). Standards of Medical Care in Diabetes-2018. *Diabetes Care*, 41, S13–S27. doi: 10.2337/dc18-S002

³⁴ [JPO: Journal of Prosthetics and Orthotics](#)

³⁵ Hughes, D.R., Filar, C. & Mitchell D.T. (2022). Nurse practitioner scope of practice and the prevention of foot complications in rural diabetes patients. *Journal of Rural Health*, 38(4), 994-998. <https://pubmed.ncbi.nlm.nih.gov/34101273/>

provision of health care or ensure access to high-quality primary care for Medicare patients. This includes accelerating efforts to support value-based care, reform the Merit-based Incentive Payment System and improve the Medicare reimbursement structure for primary care. We also appreciate the constructive conversations the bill sponsors have held with stakeholders, including the nursing community, and their receptivity to feedback on ways to continue to improve the Medicare program. We look forward to working with the Committee and bill sponsors on moving this legislation forward and continuing to refine these efforts to improve patient access to high-quality health care. There are two sections which we believe are important to highlight.

Section 102: Hybrid Payment Model for Primary Care

The hybrid primary care demonstration model included in this legislation contains many aspects which we believe will improve patient access to primary care (such as waiving cost-sharing) and support primary care clinicians and their practices. We appreciate the recognition of nurse practitioners as core primary care practitioners within this section. Primary care has been historically underpaid and undervalued, and hybrid payment models have been effective ways to ensure that primary care clinicians have the resources to provide comprehensive primary care to their patients.

We recognize and applaud the goals of this legislation in working to rectify this historic underpayment of primary care that has negatively impacted Medicare beneficiaries. MedPAC's 2018 Report to the Congress *Medicare and the Health Care Delivery System* stated that "this mispricing may lead to problems with beneficiary access to these services" which are "essential for a high-quality, coordinated health care delivery system."³⁶ The Commission stated that the systemic undervaluation of E&M services was partially "because the fee schedule is budget neutral, ambulatory E&M services become underpriced through a process of passive devaluation."³⁷ We appreciate that this legislation takes multiple steps to address these well-documented concerns.

In its 2015 report, GAO recommended "to help improve CMS's process for establishing relative values for Medicare physicians' services, the Administrator of CMS should incorporate data and expertise from physicians and other relevant stakeholders into the process as well as develop a timeline and plan for using the funds appropriated by the Protecting Access to Medicare Act of 2014."³⁸ In recent rulemaking, CMS has worked to improve the valuation process and solicited feedback from stakeholders on ways to do so. As you consider further action on accurate valuation and supporting primary care, we encourage legislation that supports CMS in these efforts.

For nurse practitioners, these disparities can be even more stark because fee-for-service Medicare reimburses NPs at a 15% reduction for services which require the same amount of work, time and intensity regardless of the clinician who is providing them. As this legislation moves forward, it is essential to ensure that the per-member-per-month payments are standardized for all clinicians participating in the demonstration. NPs are required to meet the same standards for billing, include the same documentation, and provide the same care to patients. This 15% differential is significant and is in addition to other factors which impact reimbursement rates, including statutory reductions and corresponding adjustments to the conversion factor.³⁹ This inequitable reimbursement structure is an anachronism, does not reflect the modern health care system, and should not be carried over into other Medicare payment mechanisms.

³⁶ [jun18_medpacreporttocongress_rev_nov2019_note_sec.pdf](#)

³⁷ [jun18_ch3_medpacreport_sec.pdf](#)

³⁸ [Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy | U.S. GAO](#)

³⁹ [CY 2024 Medicare Physician Fee Schedule Final Rule](#)

We also stress the importance of ensuring that patients are properly attributed to the clinicians providing their primary care. Certain billing mechanisms, such as incident-to, can often obscure the clinician who is treating the patient. To promote continuity of care and patient choice, an attribution method that correctly identifies the patient-clinician relationship is essential. Additionally, while this section provides the Secretary the authority to develop a risk-adjustment mechanism, we encourage additional guidance to be given to CMS to promote a risk-adjustment policy that truly accounts for frailty, clinical complexity, social risk, rurality, and other factors that materially affect the resources required to care for Medicare beneficiaries.

AANP also supports continued discussion regarding the definition of “independent practice” for the purposes of participating in the demonstration model. While we understand and agree with the intent of this provision, an overly restrictive definition could inadvertently exclude many practices and patients who would benefit from the demonstration, including safety net providers, NP-owned practices, and practices that are aligned with accountable care organizations. We look forward to working with the Committee on continued refinement of this definition so that the demonstration model achieves its intent.

Section 403 of Patients First Act and Further Consultation on Accurate Valuations

In Section 403 of the *Patients First Act*, on updating direct costs used to calculate practice expense RVUs, we respectfully request that the language regarding consultations be amended to say “clinician specialty societies.” We agree with the importance of consulting external experts on practice expenses, and it is critical that this consultation includes the nursing community and other clinician experts, who can provide feedback on practice expenses. Lack of input and information from the nursing community in survey data has been raised by CMS as an issue in determining practice expenses. Updating the language in this section to include nursing and other clinicians will help foster a more comprehensive approach to accurately assessing practice expense data. This is also consistent with the language in other sections of the legislation regarding advisory committees for the POINTS program, and we appreciate the recognition of including all relevant clinicians, including nurse practitioners, in the advisory committees. Within all committees, we also place an emphasis on representation from clinicians who are currently in clinical practice to ensure relevance with current clinical workflows.

Conclusion

We appreciate the Committee’s recognition of the need to address the structural limitations within the Medicare program which inhibit beneficiary access to coordinated patient-centered care, and the importance of including nurse practitioners in these efforts. We look forward to working together on improving and modernizing the Medicare program to reflect the current health care workforce and to meet the needs of Medicare patients. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.



Congress of the United States
House of Representatives
Washington, DC 20515-0916

September 15, 2026

*Statement Submitted for the Record on Energy & Commerce Health Subcommittee Hearing:
"Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health
Care Cybersecurity"*

Dear Chairman Guthrie and Subcommittee Chairman Griffith:

Thank you for holding this important hearing to address challenges in Medicare provider payments and strengthen our health care system. I am pleased to see my bill, H.R. 6130, the "Alzheimer's Screening and Prevention Act," included for discussion.

This bipartisan, bicameral legislation ensures Medicare beneficiaries have access to Medicare-covered early detection screening tests for Alzheimer's disease and related dementias, helping detect these diseases earlier and giving patients and families more time to plan and act.

I look forward to continuing to work together to advance this important piece of legislation.

Sincerely,

A handwritten signature in blue ink, appearing to read "Vern Buchanan", written in a cursive style.

Vern Buchanan
Member of Congress



September 3, 2026

The Honorable Brett Guthrie
Chairman
House Energy & Commerce Committee
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy & Commerce Committee
2101 Rayburn House Office Building
Washington, DC 20515

The Honorable Jason Smith
Chairman
House Ways & Means Committee
1011 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Ways & Means Committee
372 Cannon House Office Building
Washington, DC 20515

RE: Support for the Alzheimer's Screening and Prevention (ASAP) Act (H.R. 6130/S. 3267)

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Smith and Ranking Member Neal:

As clinician members of the Alliance for Patient Access, we are writing in support of the ASAP Act (H.R. 6130/S.3267). The legislation would modernize Medicare coverage to improve access to early Alzheimer's detection tools.

Founded in 2006, AfPA is a national network of policy-minded health care providers who advocate for patient-centered care. AfPA supports health policies that reinforce clinical decision making, promote personalized care and protect the clinician-patient relationship. Motivated by these principles, AfPA members participate in clinician working groups, advocacy initiatives, stakeholder coalitions and the creation of educational materials. AfPA manages an Alzheimer's Initiative, which convenes providers dedicated to ensuring a patient-centered approach to Alzheimer's disease treatment.

An estimated 7.4 million Americans age 65 and older live with Alzheimer's disease, and that number could nearly double by 2060, underscoring the urgent need for earlier diagnosis and treatment.¹ The disease's toll is already severe: one in three older adults dies with Alzheimer's disease or another dementia. The financial burden is equally significant. In 2026, total payments for health care, long-term care, and hospice services for people living with Alzheimer's or other dementias are projected to reach \$409 billion. Average per-person Medicare payments for beneficiaries with Alzheimer's or other dementias are nearly three times as great as payments for beneficiaries without these conditions. The costs of inaction on Alzheimer's disease to patients, families, and the Medicare program are substantial and growing.

Blood-based biomarker testing represents a significant advance in Alzheimer's diagnosis. In May 2025, the FDA cleared the first blood test for Alzheimer's disease to aid diagnosis in symptomatic patients age 55 and older.² In October 2025, the FDA cleared a second test, specifically for use in the primary care setting to help

¹ <https://www.alz.org/alzheimers-dementia/facts-figures>

² <https://www.fda.gov/news-events/press-announcements/fda-clears-first-blood-test-used-diagnosing-alzheimers-disease>

rule out Alzheimer's-related amyloid pathology.³ As recently as August of this year, an additional test was cleared by the FDA, establishing the first exclusionary and confirmatory blood-based biomarker test for Alzheimer's disease. These tests offer a minimally invasive, more accessible alternative to PET imaging and cerebrospinal fluid testing, both of which are costly, limited in availability, and often require a specialist referral. These clearances reflect a diagnostic field advancing faster than the coverage policies meant to keep pace with it.

These diagnostic advances are especially significant considering new treatment options. In recent years, the FDA has approved several amyloid-targeting therapies that target the underlying biology of Alzheimer's disease and have been shown to slow disease progression in patients with mild cognitive impairment or mild dementia. Both treatments require confirmation of amyloid pathology before they can be prescribed, meaning timely access to biomarker testing is now a prerequisite for patients to be evaluated for these therapies. This evolution in treatment options has been profound, as previous therapeutics for Alzheimer's disease strictly addressed symptomatic concerns.

Beyond current applications, biomedical innovation in Alzheimer's continues to expand. There are now tests and therapies in development that both identify and treat abnormal tau protein accumulation, another of the biological processes that cause Alzheimer's disease.

As the evidence base for blood-based biomarkers continues to grow and additional tests move through the FDA review process, consistent Medicare coverage will be essential to ensuring these tools reach patients in a timely and predictable way, allowing patients to make informed decisions and access appropriate treatment.

Under current law, however, Medicare cannot cover a screening test unless Congress specifically allows for it or the U.S. Preventive Services Task Force recommends it, a process that can take years to complete. The ASAP Act fills that gap, giving HHS the authority and flexibility to ensure that outdated policies do not hinder access to screening, diagnosis and treatment.

Alzheimer's disease is often diagnosed late, after symptoms have already progressed and treatment options are more limited. For Medicare beneficiaries, who make up the population most affected by this disease, reliable coverage of blood-based biomarker testing is critical to identifying patients early, when treatment and lifestyle interventions are most effective.

The ASAP Act would support earlier diagnosis and increased treatment options by:

- Giving HHS greater authority to provide coverage for preventive services
- Allowing Medicare Part B to cover routine, FDA-approved or cleared, blood-tests for Alzheimer's disease and related dementias
- Reducing administrative burden on clinicians and clarifying reimbursement policies

Coverage of these tests can provide additional information that may allow for expedited diagnosis and earlier intervention. This means clinicians can identify at-risk patients earlier in the disease process and explore expanded treatment options, while patients and caregivers gain additional time and information to make decisions about their treatment journey.

³ <https://www.alz.org/news/2025/fda-clearance-blood-test-primary-care-rule-out-alzheimers-related-amyloid-pathology>

It is for these reasons that we urge your support for the ASAP Act, legislation that will help ensure comprehensive biomarker blood test coverage for Alzheimer's disease. If we can provide further details or answer any questions, please reach out to pmarvin@allianceforpatientaccess.org or (202) 951-7097.

Sincerely,

Lealani Mae Acosta, MD, MPH
Vanderbilt Health
Nashville, TN

Alireza Atri, MD, PhD
Banner Health
Sun City, AZ

Allison Batchelor, MD
Geriatric Medicine Consulting
Athens, OH

Corey Bolton, PsyD
Vanderbilt Health
Nashville, TN

Ciaran Considine, PhD
Vanderbilt Health
Nashville, TN

Spencer Diehl, LCSW
Vanderbilt Health
Nashville, TN

Howard Kirshner, MD
Vanderbilt University Medical Center
Nashville, Tennessee

Cara Leahy, DO
Memorial Health
Owosso, MI

Katherine McDonell, MD
Vanderbilt Health
Nashville, TN

Aaron McMurtray, MD
Vanderbilt Health
Nashville, TN

Amalia Peterson, MD
Vanderbilt Health
Nashville, TN

Chase Presley, PhD
Vanderbilt Health
Nashville, TN

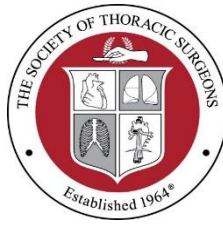
Raymond Romano, PhD, MPH
Vanderbilt Health
Nashville, TN

Johannes Schlachetzki, MD
UC San Diego
San Diego, CA

Emily Smith, LCSW
Vanderbilt Health
Nashville, TN

Douglas Terry, PhD
Vanderbilt Health
Nashville, TN

Guiyun Wu, MD
Vanderbilt Health
Nashville, TN



Statement for the Record
Submitted to the House Committee on Energy and Commerce Subcommittee on Health
“Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care
Cybersecurity.”
September 15, 2026

The Society of Thoracic Surgeons (STS) appreciates the opportunity to provide feedback on the critical issues raised during the Subcommittee’s “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity.” Founded in 1964, STS is a not-for-profit organization representing more than 8,000 surgeons, researchers, and allied health care professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lungs, and esophagus, as well as other surgical procedures within the chest.

As the Subcommittee considers proposals to strengthen Medicare provider payment, STS welcomes the opportunity to highlight policies that directly affect the ability of cardiothoracic surgeons to provide high-quality, timely care to Medicare beneficiaries. Years of declining Medicare physician reimbursement, rising practice costs, and ongoing instability created by budget neutrality have placed increasing pressure on physician practices and threaten long-term patient access to specialty care. Cardiothoracic surgeons are particularly affected by payment policies that fail to account for the complexity, intensity, and resources required to deliver surgical care. STS strongly supports congressional efforts to establish a more stable, predictable, and sustainable Medicare physician payment system and appreciates the Subcommittee’s consideration of several proposals that would advance this goal.

Patients First Act

STS supports the Patients First Act and appreciates the bipartisan effort to address longstanding challenges within the Medicare Physician Fee Schedule. The legislation represents an important step toward a more stable and predictable physician payment system and includes meaningful reforms that would help strengthen Medicare reimbursement over the long term.

While the Patients First Act would provide important long-term reforms, physicians continue to face immediate payment instability under the current system. STS is particularly concerned about ongoing cuts to surgical care and the approximately 2.5% reduction in physician payment proposed for 2027. At a time when physician practices continue to face rising costs for staff, supplies, equipment, and other expenses, further reductions in Medicare reimbursement threaten the sustainability of practices and patients’ access to care.

STS urges Congress to advance H.R. 9693, the Patients First Act, while also addressing the immediate payment reductions physicians will face in 2027. Meaningful Medicare physician payment reform must not

only correct the structural flaws that have contributed to years of declining reimbursement but also provide stability in the near term so physicians can continue delivering high-quality care to Medicare beneficiaries.

Provider Reimbursement Stability Act

STS strongly supports targeted reforms to Medicare's budget neutrality policies to provide greater stability and predictability for physician payment. Under current law, budget neutrality requirements can result in significant, across-the-board reductions to the Medicare Physician Fee Schedule (MPFS), even when changes in spending are based on projections that ultimately do not reflect actual utilization. The legislation under consideration would address several longstanding flaws in this system through three important reforms.

First, the legislation would modernize the \$20 million spending threshold that triggers a budget neutrality adjustment. This threshold has not been updated for inflation since it was established decades ago. The bill would increase the threshold to \$54 million and subsequently adjust it every five years based on the cumulative increase in the Medicare Economic Index (MEI). This change would prevent relatively minor changes in the valuation or utilization of services from unnecessarily triggering across-the-board payment reductions.

Second, the legislation would improve the accuracy of budget neutrality adjustments by allowing CMS to reconcile projected utilization with actual claims data. CMS can overestimate the utilization of new or revalued services, resulting in larger payment reductions than necessary. Establishing a lookback process would allow CMS to correct inaccurate projections and adjust the conversion factor based on actual utilization.

Third, the legislation would limit budget neutrality adjustments to 2.5% in any single year. This safeguard would protect physician practices from large, abrupt reductions in Medicare reimbursement and provide greater year-to-year payment stability.

Together, these reforms would make Medicare's budget neutrality policies more accurate, predictable, and sustainable. **STS supports enactment of these provisions as a major step toward protecting the financial viability of physician practices and preserving Medicare beneficiaries' access to high-quality care.**

Access to Claims Data Act

Clinician-led clinical data registries are essential tools for improving health care quality and advancing research. These registries collect detailed, standardized clinical data on procedures, treatments, and patient outcomes, and provide meaningful feedback to participating clinicians. By generating robust quality and outcomes data, registries support quality improvement, patient safety, research, and the transition to value-based care.

However, clinical registry data alone often provides an incomplete picture of a patient's long-term outcomes. For example, the STS National Database captures outcomes within a limited post-treatment period, restricting the ability to evaluate longer-term outcomes and the durability and effectiveness of interventions. Linking clinical registry data with Medicare claims data can help fill these gaps by allowing registries to follow patients over longer periods and better understand outcomes, utilization, and costs.

Congress has already recognized the importance of this linkage. Section 105(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) directs CMS to provide Medicare claims data to qualified clinical data registries for linkage with clinical outcomes data to support risk-adjusted analyses, quality improvement, patient safety, and research. Meaningful access to federal claims data would allow clinician-led registries to better track long-term patient outcomes, assess the safety and effectiveness of treatments, and evaluate the relative costs and benefits of different therapies.

Despite this potential, significant barriers continue to limit access to Medicare claims data. One of the primary challenges is the Virtual Research Data Center (VRDC), which provides access to Medicare data but can be slow, complex, and prohibitively expensive. Access is tied to narrowly defined research projects, the approval process can take months, and substantial costs can deter registries from pursuing projects altogether. These barriers limit the ability of clinician-led registries to use claims data efficiently and at scale for ongoing quality improvement and research.

Removing these obstacles would allow clinician-led registries to more effectively fulfill their role in improving patient care and generating evidence about long-term outcomes. **We urge the Committee to pass H.R. 4331, the Access to Claims Data Act, to facilitate the transfer of federal claims data to eligible clinician-led clinical data registries and reduce unnecessary barriers to data access.**



AMERICAN COLLEGE OF GASTROENTEROLOGY

11333 Woodglen Drive, Suite 100, North Bethesda, Maryland, 20852-3071
P: 301-263-9000; F: 301-263-9025; Website: www.gi.org

Statement for the Record from the American College of Gastroenterology

U.S. House of Representatives Committee on Energy & Commerce, Subcommittee on Health Hearing “*Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity*”

September 14, 2026

The American College of Gastroenterology (ACG) appreciates the opportunity to submit this statement for the record for the legislative hearing entitled, “*Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity*.” We applaud the Committee, as well as the GOP Doctors Caucus and Congressional Doctors Caucus, for your leadership in reforming physician reimbursement under the Medicare program through such legislation, which we believe will improve the viability of independent practices and enhance access to patient care.

Founded in 1932 and representing over 21,000 gastrointestinal (GI) clinicians, ACG’s mission is to enhance the ability of our members to provide world-class care to patients with digestive disorders and advance the profession through excellence and innovation based upon the pillars of patient care, education, scientific investigation, advocacy, and practice management.

While our comments below address H.R. 9693, the *Patients First Act*, we urge the Committee to consider this feedback for any legislative proposal intended to reform Medicare physician reimbursement.

Primary Care Services Beyond the “Primary care” Specialty Designation

We appreciate that the *Patients First Act* includes increased payment amounts for primary care services, and so we believe this funding should be used more broadly to support primary care services regardless of specialty designation. Many GI clinicians are the de facto “primary care physician” for patients with chronic GI conditions, especially in rural communities and localities deemed as a healthcare professional shortage area (HPSA). In fact, HPSAs are defined and designated by the Health Resources and Services Administration (HRSA) as having “a shortage of health professionals in primary care, dental

health, and mental health.”¹ If the *Patients First Act* would account for this, it would more closely reflect the current practice of medicine in many communities across the U.S.

We also appreciate that these additional funds would not be subject to budget neutrality under the Medicare Physician Fee Schedule (PFS), but request that you ensure this additional funding would not affect the relativity of the PFS, which could adversely affect non-evaluation and management services.

Payment and Quality Reporting Reforms

It is critical that Congress consider lessons learned from the current payment system as it finalizes legislation to make reforms. In the *Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments* final rule (CY 2025 Medicare PFS final rule), CMS estimated roughly 38 hours of work per clinician was required to participate in the Merit-based Incentive Payment System (MIPS), at a cost of nearly \$7,800.^{2,3} However, available research suggests those figures are woefully low. In fact, one qualitative study revealed that physician practices across the U.S. spent more than 200 hours per physician on MIPS-related activities, at an average cost of \$12,811 to participate in MIPS in 2019.⁴

We are also concerned that since MIPS was established, CMS was given wide latitude to modify and implement the statutorily required elements of this program. As such, we encourage more specific parameters for the agency regarding the new “cost containment” performance category and how this differs or interacts with the “resource use” performance category. Further, we ask that you consider how cost containment and resource use measures will be linked to the quality of a particular service. We believe this is a critically important part of advancing value-based care instead of incentivizing the inappropriate stinting of care.

¹ What Is Shortage Designation? | Bureau of Health Workforce, <https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas>.

² 89 Fed. Reg. 97710 (Dec. 2024); 90 Fed. Reg. 4926 (Nov. 2025).

³ In the CY 2026 Medicare PFS final rule, CMS did not outline any updates to its burden estimates due to the burden estimates not being affected by the policy provisions in the final rule. The applicable burden changes were submitted to OMB for approval under control number 0938-1314 (CMS-10621) and can be found here: <https://omb.report/icr/202509-0938-009/doc/162402700>.

⁴ 89 Fed. Reg. 97710 (Dec. 2024); JAMA Health Forum, *Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System* (May 2021), <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947>.

Emphasis on Rural and Independent Practices

We also urge the Committee to stipulate in legislative language how a new approach to reimbursing physicians for the items and services they provide to Medicare beneficiaries will impact small and rural practices. Current assistance for small and rural practices is clearly not working. Medicare providers are exempted from MIPS if they fall below the low-volume threshold, which includes:

- Billing more than \$90,000 for Medicare Part B covered professional services;
- Treating more than 200 Medicare Part B patients; and
- Providing more than 200 professional services to Medicare Part B patients.

CMS also provides “special status” designations for rural and small practice providers. While this is well-intended, data and experience reports show that participating in the MIPS program continues to strain small and rural practices.⁵ In the *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* final rule (CY 2026 Medicare PFS final rule), CMS estimates that in 2026, nearly 50 percent of solo practices and over 20 percent of practices with 2-15 providers will receive a payment cut for failing to successfully participate in the Quality Payment Program (QPP).⁶ The estimates are roughly the same for rural practices as well.⁷ The typical participating clinician cannot rely on MIPS to help offset PFS cuts because the average adjustment for 2025 was just 0.59 percent and the median was a meager 0.90 percent. This is lower than previous years, given the removal of the “exceptional” performance adjustment in 2024. Meanwhile, the Medicare economic index (MEI) was 3.5 percent in 2025.⁸

The number of independent physicians in rural areas fell 43 percent from 21,956 in January 2019 to 12,467 in January 2024.⁹ Similarly, the number of medical practices in rural areas declined 11 percent from 30,000 in January 2019 to 26,700 in January 2024.¹⁰ Therefore, we

⁵ See Quality Payment Program, *Participation and Performance Data*, <https://qpp.cms.gov/resources/performance-data>.

⁶ 90 Fed. Reg. 4926 (Nov. 2025).

⁷ *Id.*

⁸ See <https://qpp.cms.gov/resources/performance-data>.

⁹ Becker’s Clinical Leadership, *Rural US loses 43% of independent physicians: 5 things to know*, <https://www.beckershospitalreview.com/quality/hospital-physician-relationships/rural-us-loses-43-of-independent-physicians-5-things-to-know/>.

¹⁰ Becker’s Clinical Leadership, *The state of the physician workforce in 2025*, <https://www.beckershospitalreview.com/quality/hospital-physician-relationships/the-state-of-the-physician-workforce-in-2025/>.

urge you to consider legislative solutions such as requiring CMS to stratify and calculate QPP bonuses by practice size and geographic area. The QPP experience reports clearly show that small and rural providers are at a competitive disadvantage to larger practices when trying to earn QPP bonuses. In addition, we urge you to consider additional legislative solutions such as expanding the low-volume thresholds and “special status” designations for small and rural providers to ease the burdens and challenges of participating in the QPP.

We appreciate that the bill does not rescind these current exemptions and protections for small and independent practices. We also urge the Committee to index the \$90,000 figure by inflation (e.g., MEI) and consider voluntary exemption practices for those in a HSPA or areas with a shortage of specialty physicians.

Currently, the federal government exempts small businesses from various employment and labor laws, recognizing that administrative and regulatory burdens may unfairly impact small employers. ACG encourages Congress to follow the same precedent and exempt small and independent practices, or those in professional shortage areas, from certain regulatory/reporting requirements under this new model. These types of exemptions and flexibility for smaller practices will allow them to become more efficient and competitive, supporting access to high-quality care across the country.

Conclusion

Thank you for the opportunity to submit these comments to the hearing record. We look forward to working with the Committee as it finalizes legislation to reform physician reimbursement under the Medicare program, which will increase access to care for patients and ensure a healthier and more viable business environment for private practice medicine. Please contact Brad Conway, VP Public Policy, Coverage & Reimbursement, at 301.263.9000 or bconway@gi.org to discuss further.



Statement from U.S. Renal Care, Inc.

**Committee on Energy & Commerce Health Subcommittee Hearing
Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster
Health Care Cybersecurity**

September 2026

U.S. Renal Care, Inc. (USRC) thanks Committee Chair Guthrie and Subcommittee Chairman Griffith and Committee Ranking Member Pallone and Subcommittee Ranking Member DeGette for holding the September 15 hearing “*Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity.*”

USRC is a leading provider of home and in-center dialysis. Our mission is to change the lives of people living with kidney disease for the better. USRC operates nearly 500 dialysis programs, including home dialysis programs, in 32 states, serving 37,000 individuals living with kidney failure. In 2025, USRC achieved best-in-industry outcomes in clinical performance, growth, and employee satisfaction. USRC employs approximately 10,000 people, and, in 2025, we were ranked in the top quartile of Gallup’s healthcare company benchmark on employee engagement. Our employee retention is higher than ever, and we believe it is much higher than dialysis and health care industry averages. Recently we were recognized for the third year in a row by Newsweek as a “Greatest Workplace.”

USRC performance on the Quality Incentive Program (QIP) also leads the industry. USRC has a robust research program subsidiary, USRC Kidney Research, which has emerged as a national leader in advancing clinical knowledge and improving care for patients with chronic kidney disease (CKD). Our subsidiary, Kidneylink, seeks value-based care arrangements with Medicare and private health plans, and participates in the CMS Comprehensive Kidney Care Contracting (CKCC) program with nine active KCE programs. In the most recent CKCC reporting period, Kidneylink delivered the largest total medical cost reduction in the program, and in which 60% of our KCEs received CMS’s highest rating as “high performers.”

We strive to help patients who prefer home dialysis to be able to receive the therapy. USRC’s percentage of home dialysis patients is significantly greater than the national average and has steadily risen each year since 2017. Moreover, year-after-year, USRC continues to reduce patient mortality to below the national average, which has occurred in correlation to longer treatment times. We have reduced the percentage of patients who miss treatments to less than 6 percent. We are also the leaders in effectively managing bone mineral disease, a systemic disorder causing weak, brittle bones and vascular calcification due to imbalanced calcium, phosphorus, and vitamin D.

USRC appreciates the Committee's efforts to improve innovation for dialysis patients, and we want to highlight that the TDAPA program's current structure is not working as intended. USRC welcomes the Committee's discussion of H.R.6214, the Kidney Care Access Protection Act, which contains priorities we hope the Committee, and Congress will advance this term including, legislative reforms to the TDAPA program to provide for payment to follow the patients to whom certain drugs are prescribed and a third year of the current TDAPA program for DefenCath and Vafseo. Addressing these priorities will help ensure dialysis patients have continued access to innovative therapies that improve their care and outcomes.

USRC supports a sustainable pathway for adopting innovative treatments.

USRC is a leader in innovation and adoption of new innovative therapeutics due to our strong research division. Because we were already familiar with the efficacy of these drugs, we educate our physicians, staff, and patients and quickly adopt policies that enable patients to accrue the benefits of these drugs. Unfortunately, the post-TDAPA policy adopted by CMS does not adequately support innovation, leaving patients with kidney failure to rely on status quo medicine while those living with other chronic diseases access innovation and even cures.

Individuals with kidney failure are unique in that the vast majority of patients rely on government-based health care coverage, about 90 percent of total patients. This reality upends the usual market dynamics. If CMS does not adequately reimburse for an innovative product, there is no other coverage option where the product may be available to patients.

As noted during the hearing, the case study of Korsuva demonstrates the shortcomings of the current policy. CMS policy led to underutilization by facilities. Today, only a small number of patients can access the product. In contrast, in Europe and Japan the drug's clinical value has been embraced because it has a more appropriate reimbursement pathway so that the patients it was designed to help can access it. Effective treatments for CKD-aP result in fewer patient infections, which reduces the need for antibiotics and improves antimicrobial stewardship. It also reduces hospitalizations and removes barriers to patients qualifying for transplant waitlists. The short-sighted post-TDAPA approach resulted in CMS missing out on billions of dollars in overall Medicare savings.

We agree that the initial TDAPA is temporary pass-through payment, but there needs to be a different solution once that transition period ends. That is why USRC embraces the policies included in H.R. 6214, the Kidney Care Access Protection Act. These policies would **reduce** spending under Part A by eliminating entirely preventable hospital stays. One of the products currently in its TDAPA period, Vafseo, has been shown to reduce hospitalization by 15 percent. In all, managing patients under Part B with this single drug is likely to save more than \$2 billion. Yet, CMS and the CBO do not recognize that fact in their estimates.

In addition, Representative Miller's and Representative Sewell's legislative solution promotes innovation while establishing safeguards to control spending and utilization. First, the proposal creates an adjuster to the base rate that is initially based on 65 percent of the Average Sales Price (ASP) – not 100 percent or 106 percent. This amount then “locks in” on a permanent

basis and is inflated by an appropriate proxy for inflation. In this way, the post-TDAPA adjustment **is not a pass-through payment**. It essentially creates a patient-centered adjuster that is applied only to claims for those patients who need and receive the therapy. This approach is how bundles are supposed to work, but the current policies treat every patient as if they were the same – as if they were a number – without adjusting for their unique needs.

This “capitated” amount that requires the money to follow the patient – and not the facility – also deters facilities from overutilizing the drug. They are not reimbursed at 100 percent of ASP, which creates a downward pressure; however, they will receive sufficient funds to be able to support using the drug when it is medically necessary.

The policy also eliminates the risk of underutilization that resulted in the case of Korsuva. The little funding that was available because the 3-year additional post-TDAPA funds were spread over all dialysis patients made it impractical for smaller organizations to provide the drug, even when they knew of the clinical benefit.

Even though CMS has the authority to establish a different pathway to adjust the bundle when truly innovative products are developed, it has repeatedly chosen not to exercise this authority. As a result, patients suffer, and fewer researchers and innovative companies are willing to develop new treatment options for dialysis patients. This situation leads to Medicare spending more money on status quo outcomes. This situation is unacceptable for the patients who are forced to rely on Medicare for access to health care. We strongly encourage the Committee to mark up the innovation provisions of H.R. 6214 and work for its passage before the end of this year.

Conclusion

Once again, USRC appreciates the Committee’s and Subcommittee’s careful consideration of policy reforms that will help address the challenges the kidney care community faces as we try to prevent kidney disease, slow its progression, and promote access to innovation over the status quo.

September 14, 2026

The Honorable Brett Guthrie
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Griffith, and Ranking Member DeGette:

As the leading authority on oral health in the United States, the American Dental Association thanks you for including H.R. 1521, the Dental and Optometric Care (DOC) Access Act, in the Subcommittee on Health's hearing entitled "Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity." We offer our strong support for this bipartisan legislation, which would limit contractual arrangements allowing insurance carriers to fix prices on dental and vision services they do not cover..

It is unreasonable for dental plans to set fees for services in which the plans have no financial liability, and that is why 44 states have enacted laws that limit interference with the doctor-patient relationship when the doctor delivers services insurers do not cover. However, without Congressional action, ERISA creates a loophole allowing carriers administering self-funded plans to claim an exemption from these state-level safeguards.

The current landscape harms competition and shifts costs to uncovered patients who are paying out of pocket or patients seeing an out-of-network dentist. Where insurers force discounts, the cost of care does not diminish but merely shifts within the care delivery system. Therefore, insurers' interference, left unchecked, does nothing to reduce the overall cost of care. The DOC Access Act would help ensure dental practices can focus more on patient care instead of having to navigate insurers' contractual manipulations that bolster their products at the expense of effective patient care.

A March 2026 Government Accountability Office (GAO) report underscores these concerns, finding that the three largest dental insurers in each state held a median 67% of group-market enrollment in 2024, with combined market share ranging from 38% to 98%. For the

The Honorable Brett Guthrie
The Honorable Frank Pallone, Jr.
The Honorable Diana DeGette
Page 2

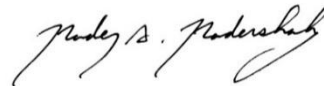
dental group market, 11 states, including Kentucky and Colorado, each had a combined market share of the three largest insurers of 80% or above.¹ GAO also noted limited research linking more concentrated dental insurance markets to lower insurer reimbursements to providers. Allowing these carriers to continue to fix prices on services they don't cover increases their leverage in the market, further concentrates their power, and shifts costs to patients who pay out of pocket. H.R. 1521 would help curb anti-patient and anti-competitive practices, address the contract imbalance favoring carriers, and support greater access to high-quality care equally, for all patients.

Passage of H.R. 1521 would balance the scales and bring equity to carrier-provider contracting at the federal level. On behalf of our members and their patients, thank you again for including this important legislation in the hearing. We respectfully urge the Committee to mark up H.R. 1521 and look forward to working with you to advance the bill. If you have any questions, please contact Ms. Natalie Hales, Senior Congressional Lobbyist, at halesn@ada.org.

Sincerely,



Richard J. Rosato, D.M.D.
President

 D.D.S., M.B.A., Ed.D.

Nader A. Nadershahi, D.D.S., M.B.A., Ed.D.
Executive Director

RJR:NAN:nh

¹ [GAO-26-107787, PRIVATE DENTAL AND VISION INSURANCE: Market Concentration Varied Among States](#)



The Nation's Advocacy Voice for In-Office
Infusion

3307 Northland Dr, Ste 160 ▪ Austin, TX 78731
www.infusioncenter.org ▪ info@infusioncenter.org

September 14, 2026

House Energy and Commerce Committee
Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

Re: Health Subcommittee Hearing, *Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity*

Dear Members of the House Energy and Commerce Committee Health Subcommittee:

The National Infusion Center Association (NICA) is a nonprofit organization that supports community-based infusion centers caring for patients who need provider-administered medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in safe, more efficient, and cost-effective alternatives to hospital care settings. Despite their value to the health system, infusion centers face significant regulatory and economic pressures that threaten their viability, including instability within the Medicare Physician Payment System.

NICA appreciates the Subcommittee's commitment to working with stakeholders to identify comprehensive, long-term solutions to the challenges facing the Medicare physician payment system. Throughout the 119th Congress, NICA has engaged with Committee members, including members of the [House Doctors Caucus](#), to provide feedback on Medicare payment reform proposals, such as the *Provider Reimbursement Stability Act* and the *Patients First Act*, and their potential impact on infusion providers and the patients they serve nationwide. We appreciate the opportunity to share our comments on the proposals currently under consideration by the Subcommittee to address structural challenges within the Medicare Physician Fee Schedule (MPFS).

H.R. 8163, the Provider Reimbursement Stability Act

NICA urges the Committee to advance H.R. 8163, the bipartisan *Provider Reimbursement Stability Act*, which would modernize the MPFS budget neutrality mechanism and provide much-needed payment stability for infusion providers. Unlike other Medicare payment systems, the MPFS does not provide physicians and other clinicians with a consistent annual inflationary update. As the cost of running infusion practices has continued to rise, providers have encountered increasing difficulties in maintaining access to care for Medicare beneficiaries. Over the past 20 years, Medicare physician payments have declined by 33 percent when adjusted for inflation, a trend that is simply unsustainable.¹

H.R. 8163 would address these issues by raising the budget neutrality threshold and establishing a permanent inflationary update linked to the Medicare Economic Index (MEI). Collectively, these reforms

¹ American Medical Association, *Medicare Updates Compared to Inflation in Practice Costs (2001–2025)*, updated Jan. 2025, <https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf>.

would enhance financial stability and predictability for infusion practices, ultimately preserving access to care for Medicare beneficiaries.

H.R. 9693, Patients First Act of 2026

NICA recognizes that the *Patients First Act of 2026* represents a significant step toward addressing long-standing structural challenges within the MPFS and appreciates the bill sponsors' efforts to develop a more sustainable and effective approach to Medicare physician payment and quality reporting.

NICA welcomes the proposed elimination of the Merit-based Incentive Payment System (MIPS), which has historically suffered from a lack of meaningful quality measures and performance benchmarks relevant to infusion providers. For many infusion practices, MIPS has become a costly and complex administrative burden, requiring significant resources for reporting, compliance, and contractor oversight without demonstrably improving patient care quality.

As the Committee considers the bill's proposed transition from MIPS to the Patient Outcome Improvement National Tabulation System (POINTS), NICA urges careful consideration of how the new program is designed and implemented so that it does not replicate the challenges infusion providers currently face under MIPS. Specifically, we recommend that office-based infusion centers, which primarily furnish the single service line of drug administration, be exempt from POINTS when participation would not meaningfully advance quality improvement or patient care. Because infusion practices are concentrated almost entirely in infusion and drug administration services, they are particularly well suited for an expanded application of the low-volume threshold, which would provide appropriate flexibility under the new program. Additionally, the absence of infusion-specific quality measures reinforces the need to ensure that infusion providers are not subject to reporting requirements or performance measures that do not meaningfully apply to the care they provide.

We are also encouraged by POINTS' vision as a clinician-led quality program. To ensure the measures are meaningful and appropriately account for the diverse care delivered under the MPFS, we urge the Committee to ensure broad stakeholder representation on the proposed Quality Task Force. This representation should include specialized organizations, such as NICA, that can offer expertise on the unique characteristics of infusion care and the quality considerations pertinent to patients receiving provider-administered medications.

NICA appreciates the Subcommittee's continued leadership in addressing challenges within the Medicare physician payment system. We urge the Committee to advance reforms that provide greater payment stability, reduce unnecessary administrative burdens, and preserve Medicare beneficiaries' access to community-based infusion care. Please do not hesitate to contact me, should you have any questions or wish to further discuss this issue: Brian.nyquist@infusioncenter.org

Sincerely,

A handwritten signature in black ink that reads "Brian Nyquist". The signature is written in a cursive, flowing style.

Brian Nyquist, MPH
Chief Executive Officer
National Infusion Center Association

STATEMENT FOR THE RECORD

**Patrick A. DeHeer, DPM, President
American Podiatric Medical Association (APMA)**

**Before the U.S. House of Representatives
Energy & Commerce Committee
Subcommittee on Health**

**Hearing on “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster
Health Care Cybersecurity”**

September 15, 2026

Supporting the Diabetes Foot Health Access and Modernization Act of 2026 (H.R. 7905/S. 4070)

Chairmen Guthrie and Griffith, Ranking Members Pallone and DeGette, and members of the Subcommittee on Health:

APMA is grateful to the Subcommittee for including the Diabetes Foot Health Access and Modernization Act of 2026 (H.R. 7905/S. 4070) in today’s hearing and for its attention to improving access to comprehensive foot and ankle care for Americans living with diabetes.

APMA urges Congress to advance this bipartisan, bicameral legislation that would modernize outdated Medicare requirements governing therapeutic shoes for individuals with diabetes and address an inconsistency in federal Medicaid law that can restrict beneficiaries’ access to podiatric physicians.

H.R. 7905 is championed by Representatives John Joyce, MD (R-PA), Diana DeGette (D-CO), Mike Rulli (R-OH), Kim Schrier, MD (D-WA), Mike Kennedy, MD (R-UT), and Darren Soto (D-FL). The Senate companion bill – S. 4070 – is led by Senators Todd Young (R-IN) and Raphael Warnock (D-GA). APMA is grateful for these Members’ bipartisan leadership in advancing legislation that recognizes federal policy should facilitate – not impede – timely access to medically necessary care for individuals with diabetes.

Modernizing the Medicare Therapeutic Shoe Benefit

In 1987, Congress established Medicare coverage for therapeutic shoes for individuals with diabetes because of the important role appropriately fitted footwear can play in preventing serious foot

complications. The benefit's regulatory framework and documentation requirements are seriously outdated as they do not reflect the realities of modern healthcare delivery. Given the widespread adoption of electronic health records and other technologies that now allow physicians to seamlessly share and access clinical information, these nearly 40-year-old documentation requirements are unnecessarily burdensome, administratively inefficient, and delay patient's access to care.

Current requirements can result in an unnecessarily cumbersome documentation process involving multiple physicians and repeated exchanges of records before a patient can obtain therapeutic shoes. These requirements can delay care even when the podiatric physician evaluating and treating the patient's lower-extremity condition has already documented the clinical findings demonstrating the need for therapeutic footwear.

These delays have real consequences. In an APMA member survey, 58 percent of responding podiatrists reported waiting one month or longer to obtain necessary documentation from the physician managing the patient's diabetes, and 45 percent reported that documentation delays prevented them from prescribing therapeutic shoes to at least 30 percent of patients who needed them.¹

For an individual with diabetes who has neuropathy, poor circulation, a history of ulceration, foot deformity, or a prior amputation, a delay of weeks or months is significant. Properly fitted therapeutic footwear is intended to reduce pressure and protect vulnerable areas of the foot before another wound or other complication develops.

The Diabetes Foot Health Access and Modernization Act would modernize this process while preserving appropriate clinical and program-integrity safeguards. Podiatric physicians are frequently the physicians diagnosing and treating the very conditions that establish a patient's need for therapeutic footwear. Requiring duplicative documentation from another physician when the relevant clinical information is already documented by the treating podiatric physician can add delay without improving the quality of the medical record or the care the patient receives.

The legislation also strengthens program-integrity protections by adding therapeutic shoes to the designated health services addressed under the physician self-referral provisions of section 1877 of the Social Security Act.

Taken together, these reforms provide a more efficient documentation pathway while maintaining accountability and safeguards against inappropriate utilization.

Modernizing Medicaid to Improve Diabetes Foot Care and Reduce Costs

The Diabetes Foot Health Access and Modernization Act would help ensure that Medicaid beneficiaries, particularly those with diabetes, have access to podiatric physicians for medically necessary foot and

¹ American Podiatric Medical Association, *Diabetic Shoe Survey Results*, available at <https://www.apma.org/apmamain/document-server/?cfp=/apmamain/assets/file/diabetic%20shoe%20survey%20results.pdf>.

ankle care. Timely podiatric care can help prevent costly complications, including ulcers, infections, hospitalizations, and amputations.

For example, when Arizona Medicaid eliminated podiatry coverage, diabetic foot ulcer hospitalizations increased 36.7 percent, severe outcomes increased 49 percent, and researchers estimated that every \$1 “saved” on podiatry was associated with \$48 in additional hospitalization charges.² Arizona subsequently reinstated Medicaid coverage for podiatric services for adults.

The legislation would help ensure more consistent access to care by podiatrists across state Medicaid programs. According to APMA’s analysis, only three states currently do not include podiatrists in their Medicaid programs for adult beneficiaries. By improving access to preventive and specialized podiatric care, Congress can help improve outcomes for Medicaid beneficiaries while avoiding more costly complications.

Improving Access Before Complications Become More Serious

The Medicare and Medicaid provisions of H.R. 7905/S. 4070 share a common goal: ensuring that patients with diabetes can access appropriate foot and ankle care before preventable conditions become more serious, costly, and potentially life-altering.

Recent evidence further demonstrates the policy importance of ensuring access to podiatric care. A 2026 *JAMA Network Open* study of Medicare beneficiaries with diabetic lower-extremity wounds found that, among the health-care factors examined, greater podiatrist supply was the only factor significantly associated with lower rates of major amputation. These findings suggest that policies that improve access to foot and ankle care provided by a podiatrist may help reduce preventable amputations and the substantial costs associated with advanced diabetic foot complications.³

Conclusion

For Americans with diabetes, timely access to foot and ankle care help prevent serious and costly complications. **APMA respectfully urges Congress to enact the Diabetes Foot Health Access and Modernization Act (H.R. 7905/S. 4070) and include these bipartisan provisions in the next appropriate health-care legislative package.**

APMA appreciates the Subcommittee’s attention to this important issue and the opportunity to submit this statement for the record.

² Grant H. Skrepnek, Joseph L. Mills & David G. Armstrong, “Foot-in-Wallet Disease: Tripped Up by ‘Cost-Saving’ Reductions?,” *Diabetes Care* 37, no. 9 (2014): e196–e197, doi:10.2337/dc14-0079.

³ Ioana Popescu et al., “Geographic Variation in Amputations for Medicare Patients With Diabetic Lower-Extremity Wounds,” *JAMA Network Open* 9, no. 5 (2026): e2613616, doi:10.1001/jamanetworkopen.2026.13616.



Statement for the Record of Heart Rhythm Advocates
House Committee on Energy and Commerce
Subcommittee on Health
Examining Legislative Proposals to Reform Medicare Provider
Payment and Bolster Health Care Cybersecurity
September 15 2026

Chairman Griffith, Ranking Member DeGette, and members of the Subcommittee: Heart Rhythm Advocates appreciates the opportunity to submit this statement for the record regarding the legislative proposals before the Subcommittee. Heart Rhythm Advocates represents physicians and other healthcare professionals who diagnose and treat heart-rhythm disorders, including atrial fibrillation, ventricular arrhythmias, inherited rhythm disorders, and conditions that can result in stroke, heart failure, or sudden cardiac death. Cardiac electrophysiology combines longitudinal medical management, advanced diagnostic services, complex procedures, implanted cardiac devices, and continuous remote monitoring. Delivering this care requires multidisciplinary clinical teams, sophisticated technology, substantial infrastructure, and sustained investment in professional expertise. The proposals on the hearing docket could affect electrophysiology through Medicare payment stability, budget neutrality, quality reporting, practice-expense valuation, site of service, access to claims data, advanced diagnostic imaging, remote monitoring, and healthcare cybersecurity.

Summary of recommendations

- Advance H.R. 9693 and H.R. 8163, whether individually or as components of the next viable Medicare legislative package.
- Protect independent, small, rural, and specialty practices in any replacement for the Merit-based Incentive Payment System.
- Require specialty-appropriate measures, reliable attribution, transparent data, and prospective testing before performance-based payment adjustments apply.
- Ensure that any expansion of office-based procedural care is clinically appropriate and subject to consistent safety, accreditation, and emergency-preparedness standards.
- Avoid reactivating imaging requirements that recreate prior authorization, impose unnecessary administrative burden, or delay time-sensitive cardiac care.
- Preserve access to clinically appropriate remote monitoring and provide practical cybersecurity support to smaller and rural providers.

The need for structural Medicare physician payment reform

Medicare's physician-payment system does not provide the stability necessary to sustain access to specialty care. Practice costs (including clinical staffing, equipment, rent, cybersecurity, regulatory compliance, and information technology) continue to increase while Medicare payment updates have repeatedly failed to reflect those costs.

Congress has frequently responded to scheduled payment reductions with temporary relief. Although these interventions have prevented deeper immediate cuts, they have not corrected the structural problems that produce instability year after year. That instability is especially

challenging for independent and community-based practices. It can delay hiring, discourage investment in technology, and accelerate consolidation into larger hospital systems. In rural and underserved areas, the loss of a specialty practice may force patients to travel considerable distances for care.

For electrophysiology patients, delayed access can have serious consequences. Delays in evaluation, diagnostic testing, device management, or procedures can increase the risk of stroke, heart failure, hospitalization, syncope, or sudden cardiac death. Medicare payment policy should support timely intervention, longitudinal management, and the infrastructure required to monitor high-risk patients between visits.

H.R. 9693 Patients First Act of 2026

Heart Rhythm Advocates strongly supports the central reforms in H.R. 9693. Beginning in 2027, the bill would establish an annual update to the nonqualifying alternative payment model conversion factor equal to the Secretary's estimated increase in the Medicare Economic Index minus one percentage point, subject to a floor and ceiling tied to the MEI. The qualifying APM conversion-factor update would be 0.5 percentage point higher. This approach would create a more predictable relationship between Medicare payment and the cost of operating a medical practice than the current cycle of scheduled reductions and short-term congressional interventions.

Predictable updates would help practices make responsible decisions about clinical staffing, equipment, technology, and patient services. They would also help preserve independent practices and maintain access in communities where specialist availability is already limited. The bill would also modernize Medicare's budget-neutrality policies. The existing threshold has not kept pace with the size or complexity of the physician fee schedule. As a result, recognition of new services or correction of previously undervalued services can produce reductions affecting physicians throughout the system. Budget neutrality should not force specialties to compete against one another whenever Medicare recognizes innovation or updates a service. A higher, indexed threshold and improved safeguards would reduce unnecessary volatility while preserving appropriate fiscal accountability.

H.R. 9693 would further transition MIPS into the Patient Outcome Improvement National Tabulation System, or POINTS. HRA supports meaningful quality measurement and accountability, but measures must reflect clinical outcomes, recognize specialty care, and provide actionable information. The development and implementation of POINTS should include meaningful input from practicing physicians, specialty societies, qualified clinical data registries, and patients. Electrophysiologists should not be evaluated using measures that do not accurately reflect the patients they treat or the services they furnish.

We understand H.R. 9693 is comprehensive and may be difficult to enact as a stand-alone measure. We nevertheless urge the Subcommittee to use its principal provisions as a framework for reform and to incorporate them into the next viable Medicare legislative package if the bill cannot advance independently.

H.R. 8163 Provider Reimbursement Stability Act of 2026

Heart Rhythm Advocates also strongly supports H.R. 8163. The bill would increase the dollar threshold that triggers a budget-neutrality adjustment, index that threshold for future years, improve the information available to CMS and stakeholders when utilization differs from projections, and phase in certain significant payment reductions over two years.

A medical practice should not first learn about a consequential payment reduction only months before it takes effect. Earlier and more transparent information would allow physicians, professional societies, and policymakers to identify errors, evaluate specialty-level effects, and propose appropriate corrections. Comparing projected utilization with actual utilization would also improve the accuracy and credibility of the budget-neutrality process.

Phasing in large adjustments would protect patient access. A sudden reduction can force a practice to defer hiring, discontinue a service, or reconsider whether it can continue accepting Medicare patients. Gradual implementation allows practices to adapt without abrupt disruption. H.R. 8163 would not resolve every weakness in Medicare physician payment, but it would reduce volatility and provide practical near-term protection while Congress considers broader reform. We urge the Subcommittee to advance it alongside the structural reforms in H.R. 9693.

H.R. 8622 Medicare Physician Data Driven Performance Payment System Act of 2026

H.R. 8622 would replace MIPS with a Data-driven Performance Payment System that relies more heavily on claims-based measures and provides participating clinicians with quarterly performance information. HRA agrees that MIPS requires fundamental reform. More timely feedback and reduced reliance on clinician-reported data could lower administrative burden and make performance information more useful.

Several elements require careful review. Claims can establish that a service occurred, but they often cannot show clinical appropriateness, disease severity, patient preference, procedural complexity, or why a particular treatment was selected. Claims-only measurement may therefore produce misleading comparisons among electrophysiologists treating different patient populations.

Patient attribution presents a related concern. Electrophysiologists frequently participate in the care of patients with multiple cardiovascular and noncardiovascular conditions. A specialist should not be held responsible for costs or outcomes primarily attributable to care furnished by other clinicians or to conditions beyond the specialist's reasonable control. The proposal's payment multipliers make measurement accuracy especially important. Beginning with 2028, the bill contemplates an adjustment factor of 1.25 for performance above the applicable threshold, 1.0 at the threshold, 0.75 below the threshold, and 0.5 for nonreporting clinicians. Before adjustments of that magnitude apply, CMS should validate the measures, attribution methods, benchmarks, risk adjustment, and underlying data for each affected specialty. Clinicians should have a meaningful opportunity to review and correct data before payment consequences attach.

We appreciate the bill's recognition of practices with 15 or fewer eligible professionals. Congress should consider additional protections for rural practices, shortage-area physicians, and specialties for which sufficiently reliable claims-based measures do not exist. Any replacement for MIPS should be developed with practicing physicians and specialty societies, tested before financial consequences apply, and designed to reward meaningful improvement rather than documentation or coding proficiency.

H.R. 7863 Promoting Fairness for Medicare Providers Act of 2026

H.R. 7863 would establish a Medicare facility payment for certain high-supply-cost surgical procedures performed in an office-based facility that meets specified conditions. In general, the payment would equal 90 percent of the ambulatory surgical center facility amount for an eligible procedure, with a separate methodology for device-intensive procedures.

The proposal could affect certain device-intensive or high-supply-cost cardiovascular services. Its application to electrophysiology is uncertain, however, because the bill does not identify qualifying codes and generally relies on historical criteria, including whether a procedure was payable in both the office and ASC settings during the statutory reference year. Congress and CMS should identify the eligible procedures publicly and analyze specialty-specific effects before implementation.

Electrophysiology procedures vary substantially in complexity and patient risk. Some patients may be appropriate candidates for care outside a hospital; others require hospital resources. Payment policy should not encourage a patient to receive care in a setting that is not clinically appropriate. Any participating office-based facility should meet rigorous and consistent requirements for accreditation, infection control, anesthesia, emergency response, patient selection, transfer agreements, staffing, and outcomes reporting.

Congress should also consider how historical supply-cost and site-of-service data will account for rapidly changing technology. HRA supports expanding access to clinically appropriate sites of care, but recommends further technical review of eligible procedures, payment methodology, patient-selection criteria, and safety standards before enactment or implementation.

H.R. 4331 Access to Claims Data Act

H.R. 4331 would expand access to Medicare, Medicaid, and Children's Health Insurance Program claims data for qualified clinical data registries and clinician-led registries conducting research and quality-improvement activities. HRA supports the objective of giving qualified registries appropriate access to longitudinal claims information, subject to strong privacy and security safeguards.

Clinical registries help measure outcomes, identify variations in care, and improve the safety and effectiveness of cardiovascular treatment. Linking clinical information with claims data can provide a more complete understanding of arrhythmia care, implanted-device outcomes, repeat procedures, hospitalizations, stroke, heart failure, healthcare utilization, and disparities in access.

Fees should be reasonable and should not prevent nonprofit or specialty-led registries from participating. CMS should provide information in a timely, standardized, and usable form. The bill's January 1, 2026 deadline for establishing the data-access process has already passed. The Subcommittee should update that date and provide CMS a realistic implementation period before advancing the legislation.

H.R. 5737 Radiology Outpatient Ordering Transmission Act

H.R. 5737 would reactivate and restructure Medicare's appropriate-use-criteria program for advanced diagnostic imaging. HRA supports evidence-based imaging. Cardiac CT, MRI, and nuclear imaging can be important in arrhythmia diagnosis, procedural planning, and evaluation of structural or ischemic heart disease. We are concerned, however, that the legislation could restore a burdensome administrative system without demonstrating a corresponding improvement in patient care.

The bill would shift transmission of required ordering information from claims to qualified clinical decision-support mechanisms, identify clinicians considered low compliant, and direct CMS to study potential enforcement mechanisms, including prior authorization or payment adjustments. These policies could add administrative steps and delay diagnosis. Prior authorization would be especially concerning given the burdens patients and physicians already encounter under commercial and Medicare Advantage utilization-management programs.

If Congress proceeds, it should exempt emergency and time-sensitive care, require relevant specialty-society participation in the development of criteria, establish a clear appeals and correction process, and prohibit automatic prior-authorization or payment penalties without further congressional action. CMS should demonstrate measurable improvement in appropriateness, outcomes, or program integrity before financial consequences are imposed.

The bill also uses a January 1, 2026 effective date that has already passed. The Subcommittee should correct the date and allow adequate time for technical implementation, clinician education, testing, and evaluation.

Health Care Cybersecurity and Resiliency Act of 2026 discussion draft

The unnumbered discussion draft would strengthen coordination between the Department of Health and Human Services and the Cybersecurity and Infrastructure Security Agency and expand federal support for healthcare-sector cybersecurity. Cybersecurity is a patient-safety issue for electrophysiology. Practices rely on electronic health records, remote-monitoring platforms, connected medical technology, and the secure transmission of information from implanted cardiac devices. A cyberattack can disrupt scheduling, prevent access to clinical information, interrupt remote-monitoring workflows, and delay medically necessary care. HRA encourages stronger federal coordination, timely threat information, and practical technical assistance. Policymakers should recognize that small and independent practices often lack the cybersecurity resources available to large health systems. Any new federal expectations should therefore be risk-based and accompanied by financial and technical support. Policy should also reflect the shared responsibilities of healthcare providers, device

manufacturers, technology vendors, clearinghouses, and other business associates. Unfunded mandates could inadvertently accelerate consolidation or cause smaller practices to abandon beneficial technology.

H.R. 9908 Rural Hospital Cybersecurity Enhancement Act

H.R. 9908 would support development of the cybersecurity workforce needed by rural hospitals. Rural hospitals serve as critical access points for patients requiring emergency stabilization, cardiovascular evaluation, and referral to electrophysiology specialists. Cyberattacks affecting these facilities can disrupt care across an entire region.

Targeted assistance can help rural providers recruit personnel, obtain technical expertise, and maintain secure clinical systems. Assistance should account for the connected networks through which rural hospitals communicate with specialty practices, remote-monitoring providers, and larger referral centers. Congress should also consider comparable technical support for rural physician practices and other small healthcare organizations. HRA offers these observations without taking a formal position on the bill.

Conclusion

HRA urges the Subcommittee to advance the central reforms in H.R. 9693 and H.R. 8163; ensure that any replacement for MIPS uses validated, specialty-appropriate measures and fair attribution; require strong safety protections in any expansion of office-based procedural care; expand appropriate access to claims data for physician-led quality improvement; avoid imaging requirements that recreate prior authorization or unnecessary administrative burden; protect access to clinically appropriate remote monitoring; and provide healthcare practices with the resources necessary to address evolving cybersecurity threats.

We recognize that comprehensive Medicare physician-payment reform may ultimately advance through a broader legislative package rather than as a single stand-alone bill. This hearing is an important opportunity to identify areas of bipartisan agreement and prepare durable reforms for the next viable Medicare vehicle.

Heart Rhythm Advocates appreciates the Subcommittee's attention to these issues and looks forward to serving as a resource as this work continues.



September 14, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Griffith and Ranking Member DeGette,

On behalf of the American Alliance of Orthopaedic Executives (AAOE), I write to thank you for holding this important hearing on “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity.” AAOE shares the Chairman’s goal of working to improve care for the nation’s seniors. We believe this hearing is a critical step forward in addressing the ongoing challenges associated with the current Medicare payment system, and we appreciate the Subcommittee’s continued work on this topic.

AAOE represents over 1,300 members and 660 medical practices across the country whose mission is to promote quality health care practice management in the orthopedic and musculoskeletal (MSK) industry.

AAOE advocates for stable, predictable reimbursement that allows orthopedic and MSK practices to remain financially viable and continue serving their communities. This includes supporting annual inflationary updates to the Medicare Physician Fee Schedule (PFS), addressing systemic downcoding and payer denials, and promoting payment policies that reflect the true cost of delivering MSK care. Without these safeguards, patients face reduced access to care and increased pressure to consolidate—outcomes that ultimately harm patients, employers, and local economies.

MACRA Background and Ongoing Challenges

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) fundamentally reformed Medicare physician payment by repealing the Sustainable Growth Rate (SGR) formula and replacing it with a new system of annual payment updates. It created the Quality Payment Program (QPP), which ties clinician reimbursement to performance through two pathways: the Merit-Based Incentive Payment System (MIPS) and advanced Alternative Payment Models (APMs).



6602 East 75th Street, Suite 430
Indianapolis, IN 46250



info@aaoe.net



800-247-9699

While well-intentioned at the time, MACRA—particularly through MIPS—has created significant administrative and financial burden for providers, requiring extensive data collection, reporting, upfront and ongoing investment in IT infrastructure, and compliance activities to avoid penalties. The American Medical Association (AMA) reports that compliance costs \$12,800 per physician per year and that physicians spend 53 hours per year on MIPS-related tasks. Medicare reimbursement has not kept up with the cost of inflation. Staffing, infrastructure, medical supplies, and technology costs have continued to rise. Adjusted for inflation in practice costs, Medicare physician payment has declined 33% from 2001 to 2025. Moreover, orthopaedic surgery is facing a 9% cut in CY 2027, with cuts of up to 20% for certain joint replacement procedures if CMS finalizes its proposed rule. The current environment is simply unsustainable.

Moreover, the budget-neutral “tournament” structure in which provider bonuses are funded by penalties imposed on others, exposes providers to payment cuts of up to 9%. It is notable that non-primary care specialties, such as MSK, have the lowest number of reportable measures, which may negatively impact their scores. The \$20 million budget neutrality threshold exacerbates payment reductions when triggered—most notably those experienced with the increases to outpatient evaluation and management service codes in 2021, which continue to present reimbursement cuts annually absent congressional intervention. Congress sought to prevent these annual cuts to Medicare reimbursement and associated uncertainty with the repeal of SGR. Unfortunately, ten years later, we are facing similar challenges.

In orthopedics and the broader MSK space, these challenges are amplified. MIPS measures often fail to reflect procedural complexity, and specialties like orthopedics have fewer relevant measures available—putting them at a disadvantage. Additionally, limited availability of specialty-relevant voluntary APMs has left many MSK providers with no viable pathway out of MIPS.

MACRA Reform

The current payment system is unsustainable and does not provide the adequate and predictable reimbursement structure needed to keep MSK providers solvent. AAOE believes the following principles should guide congressional MACRA reform efforts. We urge Congress to:

- Establish a permanent, predictable physician payment update tied to the Medicare Economic Index (MEI) so that Medicare reimbursement reflects the real-world costs of furnishing care. Staffing costs, medical supplies, technology investments, rent, and other administrative costs have continued to increase while Medicare physician payment has declined significantly when adjusted for inflation. A permanent MEI-based update would improve financial stability for physician practices, preserve access to care for Medicare beneficiaries, and reduce reliance on temporary congressional interventions.



6602 East 75th Street, Suite 430
Indianapolis, IN 46250



info@aaoe.net



800-247-9699

- Update the outdated budget neutrality threshold that triggers across-the-board payment reductions within the PFS. The current \$20 million threshold was established decades ago and has never been adjusted to reflect the growth of the Medicare program or physician practice expenses. As a result, even relatively modest policy changes can trigger significant reductions in the conversion factor, leading to payment instability and unintended cuts across specialties. The AAOE-supported Provider Reimbursement Stability Act would increase the threshold and index it to future increases in the MEI. Modernizing the threshold would allow CMS to make appropriate coding, valuation, and policy updates without repeatedly imposing broad payment reductions on physicians. This reform would improve payment predictability, reduce volatility, and help ensure that Medicare payment policies better reflect current clinical practice and patient needs.
- Eliminate the 2 percent Medicare sequestration. The Medicare sequestration punishes providers for fiscal concerns outside of their control. Congress should eliminate this arbitrary “tax.”
- Reduce administrative burden under MIPS. If the MIPS program continues, reforms should include streamlining reporting requirements, limiting redundant data collection, aligning measures across programs, and prioritizing clinically meaningful metrics—particularly for procedural specialties such as MSK—to lower compliance costs and allow providers to focus on patient care.
- Avoid mandatory APMs. While supportive of the transition from MIPS to APMs, AAOE does not support untested mandatory APMs. Mandatory APMs essentially force MSK providers into financially risky arrangements that could threaten their viability. Financial incentives are critical to successfully participate in models—this includes Congress extending the incentive bonus for APM participation. Ultimately, APMs should be physician-led and designed to provide support to providers via financial incentives and regulatory flexibilities.

Conclusion

AAOE appreciates the Subcommittee’s interest on this critical issue. We urge that Congress consider Medicare payment reforms that will improve stability, reduce burden, and expand access to high-quality MSK care. We look forward to being a resource. If you have any questions, please contact Chris Roy, Advocacy Council Chair at advocacy@aaoe.net.

Sincerely,



Terry Rosenthal, MBA, ATC
2026-2027 AAOE President



Chris Roy, M.Ed, ATC, LAT
2026-2027 AAOE Advocacy Council Chair



6602 East 75th Street, Suite 430
Indianapolis, IN 46250



info@aaoe.net



800-247-9699

Statement for the Record

Committee on Energy and Commerce – Subcommittee on Health
Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care
Cybersecurity

Tuesday, September 15, 2026, 10:30 AM ET

The Dermatologists Engaged for Responsible Medicine (DERM) Coalition appreciates the opportunity to provide a statement for the record in response to the U.S. House of Representatives Committee on Energy and Commerce – Subcommittee on Health’s hearing entitled *Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity*. The DERM Coalition is comprised of multiple, diverse dermatology practices, collectively representing dermatologists practicing at more than 723 locations with 10,000+ employees across 43 states and the District of Columbia. Together, our Coalition members provide comprehensive dermatological care to millions of patients each year and are therefore responsible for a significant percentage of all dermatological care provided across the United States. Coalition member practices collectively treat approximately 1.5 million Medicare and Medicare Advantage patients annually, including more than 300,000 patients whose skin cancers are diagnosed and successfully treated each year. Our Coalition members treat a disproportionately higher share of Medicare patients than the national average and given the higher risk of that population, identify skin cancer at a higher rate than the national average each year.

The DERM Coalition’s members vary in size, geographic footprint, and patient population, but they share a common concern: continued Medicare physician payment cuts, potentially compounded by recent proposals in the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) proposed rule, will jeopardize Medicare beneficiary access to timely skin care. Accordingly, we applaud the Subcommittee for holding this hearing to discuss the *Patients First Act of 2026*, introduced by Representatives John Joyce (R-PA) and Kim Schrier (D-WA), which would provide much needed stability to the PFS. We also wish to draw the Subcommittee’s attention to harmful proposals in the CY 2027 PFS proposed rule that threaten beneficiary access to dermatological care.

I. The DERM Coalition Supports the *Patients First Act of 2026*

As the Subcommittee knows, physicians have experienced year-over-year cuts to their Medicare payments. While we sincerely appreciate Congress’ efforts to offset these cuts with short-term patches, the American Medical Association (AMA) estimates that, after accounting for inflation, Medicare physician payment declined by 33 percent from 2001 through 2025. CMS proposes continuing these cuts in the CY 2027 PFS proposed rule, with reductions to the conversion factor ranging from -1.68 percent to -1.19 percent depending on whether the practitioner is a qualifying alternative payment model (APM) participant (QP). These cuts will be felt even more acutely among dermatologists, as CMS estimates that overall reimbursement for dermatology would decrease by approximately nine percent under the proposed rule.

This hearing and the *Patients First Act of 2026* present an important opportunity to identify meaningful and long-term solutions to persistent Medicare payment challenges. The bill would establish an inflation-based update for PFS payments and raise the budget-neutrality threshold, addressing two structural weaknesses that have contributed to the devaluing of physician payment.

While we appreciate Congress' short-term PFS relief, temporary fixes are not a substitute for a durable solution, and Medicare beneficiaries and the clinicians that serve them need a payment framework that provides long-term stability within the program. Prompt enactment of the *Patients First Act of 2026* would help preserve access to high-quality dermatologic care. Accordingly, we strongly support the *Patients First Act of 2026*, thank the Subcommittee for advancing the bill, and urge Congress to enact it promptly.

II. Congress Must Act to Prevent CMS's Proposals That Could Delay Access to Timely Skin Care

In the CY 2027 PFS proposed rule, CMS proposes significant payment policy changes that could impede access to timely skin care as CMS estimates that this proposed rule would negatively impact dermatologists the most. This comes at a time when dermatological care is already strained by workforce, geographic, and reimbursement challenges. We urge Congress to oppose these proposals.

First, CMS proposes to reduce payment when an office/outpatient (O/O) evaluation and management (E/M) service (reported with modifier -25) is performed on the same day as a 0-, 10-, or 90-day global procedure code. Under the proposal, CMS would pay 100 percent of the applicable amount for the highest-cost service and 50 percent for each additional O/O E/M service reported with modifier -25 or global procedure. This approach is particularly concerning in dermatology because skin cancer is often diagnosed through a same day skin evaluation and biopsy or removal of a suspicious lesion. For instance, a patient may present for a skin examination or focused skin evaluation, and a clinician may appropriately biopsy or remove a suspicious lesion during that same visit. The evaluation and procedure are distinct services and furnishing them on the same day does not reduce the clinical work required for either service.

CMS considered a similar policy in the CY 2019 PFS rulemaking cycle but did not finalize it because stakeholders raised concerns that it could encourage splitting care across multiple visits. CMS then rightfully recognized that the CY 2019 proposal could result in delayed treatment, additional visits, and longer diagnostic timelines, particularly for rural and underserved beneficiaries. While the DERM Coalition is fully committed to the highest standard of care throughout the diagnosis and treatment process, we remain concerned that this policy could further open the door to waste, fraud, and abuse in health care – in stark contrast to the Congress's and Administration's objective. Proposing this policy once again is at the detriment of patient care, and we ask Congress to urge CMS not to finalize this policy in order to protect Medicare beneficiary access to timely skin care.

Second, the DERM Coalition is concerned about CMS's proposal to remove the indirect practice cost index (IPCI) from the practice expense (PE) relative value unit (RVU) calculation. The IPCI recognizes specialty-specific indirect overhead and removing it without a replacement would fail to account for legitimate specialty-level differences in indirect PE costs. That change could place further financial pressures on practices serving rural and underserved communities, where access is already limited. CMS also has not provided sufficient information to isolate and analyze the proposal's impact, thus limiting practices' ability to comment on this proposal. Accordingly, CMS should not finalize this proposal. At a minimum, CMS should delay its implementation until transparent specialty- and code-level impacts are available and a replacement methodology for specialty-specific indirect overhead has been developed.

*

*

*

The DERM Coalition thanks the Subcommittee for its efforts to promote stability within the PFS and to advance the *Patients First Act of 2026*. We also urge Congress to oppose CMS's implementation of the harmful proposals discussed above and thereby preserve Medicare beneficiaries' access to timely, high-quality dermatological care. We stand ready to serve as a resource to the Subcommittee as it considers these important issues.

For more information about the issues raised in this statement, we have appended our comment letter on the CY 2027 PFS proposed rule. Additionally, please feel free to contact Brian Lee at brian.lee@alston.com with any questions or concerns.

September 14, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Comments of the Dermatologists Engaged for Responsible Medicine (DERM) Coalition to the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule (CMS-1848-P)

Dear Administrator Oz,

The Dermatologists Engaged for Responsible Medicine (DERM) Coalition (the Coalition) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services' (CMS's) CY 2027 Medicare PFS proposed rule. The Coalition is comprised of multiple, diverse dermatology practices, collectively representing dermatologists practicing at more than 723 locations with 10,000+ employees across 43 states and the District of Columbia. Together, our Coalition members provide comprehensive dermatological care to millions of patients each year and are therefore responsible for a significant percentage of all dermatological care provided across the United States. Coalition member practices collectively treat approximately 1.5 million Medicare and Medicare Advantage patients annually, including more than 300,000 patients whose skin cancers are diagnosed and successfully treated each year. Our Coalition members treat a disproportionately higher share of Medicare patients than the national average and given the higher risk of that population, identify skin cancer at a higher rate than the national average each year.

The Coalition's members vary in size, geographic footprint, and patient population, but we share a common principle: same-day evaluation and treatment are integral to responsible dermatologic care, especially for skin cancer identification and treatment. We are deeply concerned about the effect that the agency's proposal to reduce payment when a separately identifiable office/outpatient (O/O) evaluation and management (E/M) visit (billed with modifier -25) is furnished on the same day as a procedure carrying a 0-, 10-, or 90-day global period would have on beneficiary care. Additionally, CMS's proposal to remove the indirect practice cost index (IPCI) would undermine the financial resources that practices need to maintain access to dermatologic services. These proposals must also be considered in the context of broader reductions in Medicare physician payment for dermatologic care. Taken together, the proposed changes would place substantial pressure on practices serving communities where access to dermatologic care is already limited. The Coalition therefore urges CMS not to finalize these proposals.

A. CMS Should Not Finalize Its Proposed Payment Reduction When a Modifier -25 E/M and Global Procedure Code is Furnished on the Same Day

CMS proposes to reduce payment when a separately identifiable O/O E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, or 90-day global procedure. CMS should not finalize this proposal because: (1) CMS has not demonstrated that the purported efficiencies justify the reduction; (2) existing modifier -25 requirements already ensure that the E/M service is significant and separately identifiable; and (3) the proposal would create incentives to delay care, a risk that CMS recognizes but provides no solution for.

1. *CMS Has Not Proven There Are Efficiencies That Justify Reducing Payment for a Separately Identifiable Service*

CMS suggests that there are efficiencies when the same physician (or a physician in the same group practice) furnishes an E/M service and a global procedure to the same patient on the same day. CMS has not, however, identified evidence showing that those efficiencies exist, let alone that they amount to 50 percent of the resources required to furnish the lower-cost service.

Skin evaluation and biopsy or removal of a lesion are separately identifiable services, even if they are sequential. During the skin evaluation, the physician must still obtain the patient's history, conduct the exam, and perform the necessary medical decision-making. That work is not reduced by 50 percent because a procedure follows, and any same-day efficiencies are largely limited to ancillary activities (e.g., checking in at the front desk once).

Further, CMS has not presented empirical evidence supporting the proposed 50 percent reduction. Instead, the percentage is drawn from the multiple procedure payment reduction (MPPR), which was developed for a defined set of procedures and therapies. The percentage used for the MPPR does not, without further analysis, establish an appropriate valuation of a separately identifiable E/M service furnished in conjunction with a global procedure. CMS's request for comment on whether a 25 percent reduction might be more appropriate further demonstrates the absence of an empirical foundation for this proposal. Before proposing an arbitrary payment reduction, CMS must develop the evidence to justify that there is in fact an overlap or duplication when multiple separately identifiable services are provided on the same day.

2. *Existing Modifier -25 Requirements Already Address Whether the E/M Service Is Distinct*

CMS's proposal would also undermine the purpose of modifier -25. As the agency explains, modifier -25 identifies an E/M service "which shows the patient's condition needed a significant, separately identifiable E/M service beyond the usual procedure or service pre-operative and post-operative care."¹ For skin evaluations followed by a removal or biopsy, consistent with CMS's requirements, the E/M visit is a distinct service whose clinical elements exceed the work ordinarily associated with the procedure. Medicare Administrative Contractors (MACs) already review whether modifier -25 has been used appropriately. If CMS believes modifier -25 claims include duplicative work, it should address that concern through its existing policies rather than presumptively reducing payment for every properly billed service.

We also note that CMS has implemented an efficiency adjustment for non-time-based services, believing that procedures have become more efficient over time. The implementation of an additional efficiency adjustment for separate, significant E/M services intended to address duplicative care ironically creates an inappropriate duplicative efficiency adjustment. CMS provides no basis or evidence to support this proposal other than the belief that modifier -25 services are overpaid.

3. *The Proposal Would Create Incentives to Delay Care That CMS Has Not Addressed*

Coalition members make care decisions based on patient needs, medical appropriateness, and, unfortunately at times, payer-imposed coverage requirements. Our members have proactively treated patients on the same day in order to provide great care and convenience to patients. However, we do not

¹ *Global Surgery – MLN Booklet*, Centers for Medicare & Medicaid Services (Dec. 2025), <https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf>.

believe it is wise to create a disincentive for providing timely care, particularly given the shortage of dermatologists nationwide. CMS's payment policies influence nationwide behavior and CMS's proposed policy directly incentivizes care to be divided across multiple visits.

This risk is especially acute in dermatology, since the same day skin evaluation and biopsy or removal of a suspicious lesion is common practice and central to identifying melanoma and other harmful skin conditions. These checks are ever more critical as skin cancer rates in the United States have more than tripled from 1975 to 2021.² And of course, as CMS knows, timely detection of skin cancers, especially melanomas, is essential to prevent increased rates of morbidity and mortality. Data from the National Cancer Institute shows that localized melanomas have a 100 percent five-year survival rate. Unfortunately, those survival trends drop significantly as the cancer progresses; regionalized melanomas have a 76 percent five-year survival rate and distant melanomas have a 34 percent five-year survival rate.³ Additionally, delayed diagnoses can lead to increased costs to the Medicare program, as it is significantly more expensive to care for a beneficiary with advanced melanoma, thereby not only leading to worse outcomes, but also higher costs for the Medicare Trust Fund.⁴

During a skin check, a clinician may identify a concerning lesion or discover an incidental suspicious lesion during a visit for an unrelated condition. In either case, the clinician may appropriately perform a same-day biopsy or removal. This is a routine clinical practice in dermatology, and any efforts to change this practice could lead to patient harm as requiring an additional visit could delay diagnosis or removal by weeks or months, particularly in rural and underserved areas where access to dermatologists is limited. Fewer than 10 percent of dermatologists practice in rural areas, while approximately 40 percent practice in the 100 most densely populated areas of the country.⁵ Delaying a biopsy or removal, in addition to lengthy wait times to see a dermatologist, could push some skin cancers from an early-stage disease to a more advanced stage that is harder and more expensive to treat. We also note that not every dermatology visit must result in an additional procedure. In some instances, it would be more responsible to monitor any suspicious skin condition and perform a procedure at a later date when necessary.

CMS acknowledges that its proposal could affect scheduling services across multiple visits and refers to data-analysis tools "which may be useful in future, if necessary." The agency cites possible claim edits, comparative billing reports, and medical review capabilities to identify problematic scheduling. However, these tools appear to be neither operationalized nor prospective so by the time CMS identifies a problematic scheduling issue, the impacted beneficiary likely already experienced additional travel time, delayed diagnosis, or failed to return for necessary care.

The Coalition is assessing a future state where the lower cost service is reimbursed at 50 percent of the current payment. Should CMS finalize this, or some version of this policy, operational decisions will have to be made about clinical staff available to assist with preliminary assessments, patient intake, and other administrative tasks. Reducing payment as dramatically as CMS proposes will have a significant impact

² Kalyan Saginala, et al., *Epidemiology of Melanoma*, 9 Medical Sciences 63 (2021), <https://www.mdpi.com/2076-3271/9/4/63>.

³ *Melanoma of the Skin SEER 5-Year Relative Survival Rates, 2016-2022*, National Cancer Institute, https://seer.cancer.gov/statistics-network/explorer/application.html?site=53&data_type=4&graph_type=5&compareBy=stage&chk_stage_101=101&chk_stage_104=104&chk_stage_105=105&chk_stage_106=106&chk_stage_107=107&series=9&sex=1&race=1&age_range=1&advopt_precision=1&advopt_show_se=on&advopt_show_ci=on&advopt_show_count=on#resultsRegion0.

⁴ Leah B. Sansbury, et al., *Healthcare Resource Utilization and Cost Burden in Non-Metastatic Melanoma in the Modern Treatment Era: A Surveillance, Epidemiology, and End Results (SEER)-Medicare Analysis*, 29 Value in Health S6 (May 2026), <https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2026/poster-session-4-3/healthcare-resource-utilization-hru-and-cost-burden-in-non-metastatic-melanoma-in-the-modern-treatment-era-a-surveillance-epidemiology-and-end-results-seer-medicare-analysis>.

⁵ Toral Vaidya, et al., *Socioeconomic and geographic barriers to dermatology care in urban and rural US populations*, 78 J. Am. Academy of Dermatology 406 (Feb. 2018), [https://www.jaad.org/article/S0190-9622\(17\)32180-1/fulltext](https://www.jaad.org/article/S0190-9622(17)32180-1/fulltext).

on our continued ability to sustain our clinics, patient volumes, and our ability to identify skin cancer as early as possible and at its most treatable phase.

CMS should not implement this policy at all, and certainly not before establishing and testing an oversight framework capable of preventing inappropriate care delivery patterns, as opposed to being purely reactionary. The agency must also explain how it would distinguish legitimate scheduling decisions from efforts to maximize payment. In addition to our concerns described above, we also note that some commercial insurers implement utilization management techniques that require staged care delivery. CMS needs to be able to consistently and appropriately identify those situations that would be inappropriate from instances of scheduling delays that are due to commercial payer requirements, patient considerations, and other factors.

4. CMS Has Not Explained Why Its Concerns as Articulated in the CY 2019 PFS Final Rule No Longer Apply

CMS proposed the same 50 percent payment reduction in the CY 2019 Medicare PFS proposed rule.⁶ CMS did not finalize the proposal after numerous commenters warned that practitioners would respond by scheduling services on separate days to avoid the reduction. CMS agreed that such practices would impose “a significant undue burden for beneficiaries” and expressed “major concerns about this kind of manipulation of patient scheduling.” The agency ultimately concluded “that it must balance concerns about appropriate valuation with the potential disruptions to patient care suggested by commenters” and “[a]fter weighing these concerns, we are not finalizing the proposal to apply an MPPR to a separately identifiable office/outpatient E/M visit furnished on the same day as a global procedure.”

CMS now proposes the same reduction for CY 2027 but the current proposal does not explain why CMS is revisiting a previously rejected policy. The scheduling incentives identified during the CY 2019 rulemaking remain inherent in the proposal. Nor has CMS presented evidence demonstrating that the risk of delayed or fragmented care has materially diminished over the last 8 years. In sum, the risks remain, and CMS should not finalize its proposal to reduce payment when a separately identifiable O/O E/M service is furnished on the same day as a global procedure.

B. CMS Should Not Finalize Its Proposal to Remove the Use of the IPCI

CMS proposes to remove the IPCI from the practice expense (PE) relative value unit (RVU) methodology over a two-year phase-in period and also proposes to apply a PE stabilization adjustment that will limit annual changes to PE RVUs by no more than five percent each year. The Coalition recognizes CMS’s concerns regarding the data currently used to calculate the IPCI. However, eliminating the IPCI does not automatically eliminate legitimate specialty-level indirect overhead differences. Eliminating the IPCI without an empirically supported replacement would remove the mechanism intended to account for those differences. Increased reliance on code-level inputs is unlikely to capture costs that cannot be attributed to individual services, especially given different clinician offices provide different services. Even across our Coalition members, there are variations in the services provided based on patient needs and geographic practice areas. To assume that code-level inputs will uniformly and appropriately represent indirect practice costs for an entire specialty is inappropriate.

Complicating this issue, CMS has not provided adequate information for stakeholders to determine the impact of this proposal. Although the agency released the proposed PE RVUs at the code level, those values reflect the combined effect of multiple proposed methodological changes. Therefore, stakeholders cannot determine how much a particular change is attributable specifically to the removal of the IPCI.

⁶ 83 Fed. Reg. 35704 (July 27, 2018).

Further, CMS has not published the codes that would be subject to the proposed five percent stabilization factor. Without this information, stakeholders cannot meaningfully assess or comment on this proposal, raising concerns whether the agency followed the process as required by the *Administrative Procedure Act*. CMS therefore should not finalize its proposal to eliminate the IPCI or, at a minimum, delay its implementation until it provides the requisite transparency on the specific impacts of this proposal and develops and adopts through notice and comment rulemaking an adequate and empirically based replacement to account for specialty-level indirect overhead.

C. CMS's Proposals, in Totality, Would Compound Financial Pressures on Dermatology Practices Given the Ongoing Medicare Physician Reimbursement Cuts

The payment reductions we describe above are compounded by continued and harmful reductions of Medicare physician payments. For CY 2027, CMS proposes a -1.19 percent and a -1.68 percent reduction to the conversion factor for qualifying alternative payment model (APM) participants and non-qualifying APM participants, respectively. For dermatology, these cuts are even more severe, as the agency estimates that non-facility PFS payments will decrease by nine percent in CY 2027. We note that the agency's specialty-specific impact estimates do not disaggregate the effects of the individual proposals and as such, the Coalition's members cannot readily estimate the full impact of the proposed rule on their practices. Accordingly, the actual financial impact on our individual practices may be even greater than the agency's estimate suggests.

Although CMS has limited authority to improve the PFS, it has discretion not to finalize the proposals that we outlined in this letter. We urge the agency to carefully consider the cumulative impact that these proposals would have on dermatology practices, especially in light of recent changes to RVU valuations for procedures commonly performed by skin care practitioners. For example, in CY 2019, CMS finalized changes to the RVUs for a new skin biopsy code family. At the time, there were only two codes for skin biopsies, which were revised to a new family of six codes. These changes significantly reduced the RVUs for the more commonly performed skin biopsy services. This is the very same code family that would be severely impacted by CMS's proposed policy regarding modifier -25 O/O E/M visits.⁷ CMS must consider how these proposals could impact access to essential skin care for patients, particularly in rural communities, where fewer than 10 percent of dermatologists practice.⁸ The proposed cuts would place the greatest financial strain on the clinics least able to absorb them. Rural clinics already operate on razor thin margins, struggle to recruit physicians, and disproportionately serve Medicare beneficiaries.

Coalition members collectively operate a significant number of clinics in rural areas, with well above 10 percent – the national rate – of all practices in such areas. These cuts jeopardize our ability to maintain and provide access to skin care in these areas and could lead to closures or reductions of services, compounded by the rural healthcare workforce crisis. When a rural clinic closes, it does not shift patients to the next nearest dermatologist. For many rural Medicare patients served by our Coalition members, the next nearest dermatologist is many miles away and a meaningful share of patients facing that distance will forgo dermatological care and treatment. Reducing reimbursement in a way that threatens these clinics puts that diagnostic volume, and the patients behind it, at risk.

D. Conclusion

Given these concerns, we urge CMS not to finalize its proposals to:

⁷ See *CY 2019 PFS final rule*, 83 Fed. Reg. 59452, 59522 (Nov. 23, 2018) (finalizing code changes and RVU valuations for the skin biopsy code family).

⁸ Toral Vaidya, et al., *Socioeconomic and geographic barriers to dermatology care in urban and rural US populations*, 78 J. Am. Academy of Dermatology 406 (Feb. 2018), [https://www.jaad.org/article/S0190-9622\(17\)32180-1/fulltext](https://www.jaad.org/article/S0190-9622(17)32180-1/fulltext).

1. Reduce payment by 50 percent when a separately identifiable O/O E/M visit is furnished on the same day as a 0-, 10-, or 90-day global procedure; and
2. Remove the IPCI from the RVU calculation.

CMS has neither addressed longstanding concerns associated with these proposals nor provided the necessary evidence and data to justify these proposals. Further, the lack of transparency regarding the impact of these proposals and minimal consideration of protecting timely patient access to dermatologic care are concerning. CMS should not finalize these proposals unless and until it has sufficiently addressed these concerns. Finally, we ask that the agency consider the cumulative impact of continued cuts to dermatology services under the PFS and the disruptions these collectively have on access to care.

* * *

Thank you for the opportunity to comment on the CY 2027 PFS proposed rule. Please feel free to contact Brian Lee at brian.lee@alston.com with any questions or concerns.

Sincerely,

The Dermatologists Engaged for Responsible Medicine (DERM) Coalition

Good Morning,

I am writing to you today regarding H.R. 4299, the Protecting Patient Access to Cancer and Complex Therapies Act, a critical piece of legislation for which I am proud to be a lead sponsor. As the Energy and Commerce Health Subcommittee convenes today to evaluate more legislation, I am looking forward to more activity in the coming months where we can also give due consideration to pivotal bills like H.R. 4299.

This bill already enjoys robust backing, including the steadfast support of 14 bipartisan co-sponsors who currently sit on this very committee. Beyond the halls of Congress, H.R. 4299 has the backing of over 50 national and regional groups representing patients and providers, in addition to thousands of independent providers across the country. Given this strong consensus among our colleagues and the overwhelming support from the health care community, I believe it is imperative that we prioritize its review and advancement this year.

The urgency of H.R. 4299 cannot be overstated, as it directly impacts patient access to essential therapies in local community settings. Across the country, community-based providers are facing severe, unsustainable challenges regarding reimbursement. Without congressional intervention, these providers are staring down an impending reimbursement cut that would be nothing short of devastating to their practices. Should these cuts take effect, these independent specialists face a direct reimbursement loss of 40-60% on their drug payments, drastically reducing the ability of our most vulnerable constituents to receive timely, specialized, and life-saving care close to home.

For the sake of our patients and the local providers who serve them, we cannot afford to delay action. I respectfully ask for your support to work with me and others to successfully move this vital legislation forward. Thank you for your continued leadership and your consideration of this urgent request; I look forward to collaborating with you to protect community-based care. Sincerely,

Neal P. Dunn, M.D.
Member of Congress



September 15, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2123 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2123 Rayburn House Office Building
Washington, DC 20515

Re: Statement for the Record for the House Committee on Energy and Commerce Subcommittee on Health Hearing, “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity”

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) thanks you for holding this important hearing on “Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity.” Numerous pieces of legislation being considered by the Subcommittee today would help create long-term stabilization for the Medicare reimbursement system that has threatened the livelihood of our nation’s medical practices for years.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA’s diverse membership uniquely situates us to offer the following legislative recommendations.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was enacted to repeal the flawed Sustainable Growth Rate (SGR) formula, stabilize payment rates to physicians in Medicare fee-for-service (FFS), and incentivize physicians’ transition to value-based care models through the Quality Payment Program (QPP). While well-intentioned, MACRA’s methodology for updating the Medicare Physician Fee Schedule (PFS) does not keep pace with rising practice costs and inflation and often simultaneously cuts reimbursement for physicians.

Comprehensive reform is needed to address the multi-faceted issues undermining Medicare payment and the QPP. We appreciate the Subcommittee for discussing legislation that would address fundamental flaws with the current Medicare payment system. We offer the following recommendations on specific bills before the Subcommittee today.

Patients First Act of 2026

Medical groups continue to feel the negative consequences that the inadequate Medicare payment system has on practice operations as it exacerbates costly administrative tasks and undermines the viability of medical groups. Physician practices have been warning for years about reimbursement failing to keep up with costs and its impact on current and future Medicare patient access. Eighty percent of medical practices report Medicare payment rates do not cover the cost of care in 2026, while 84 percent of medical groups report increased operating costs.¹

Practices detail having to consider limiting the number of new Medicare patients, reducing charity care, reducing the number of clinical staff, and closing satellite locations should Medicare payment continue on this track.² The proposed 2027 Medicare Physician Fee Schedule includes another cut to physician reimbursement that amplifies these concerns and further pushes independent practices closer to selling to larger entities or shutting their doors. In addition to failing to cover the cost of providing care to Medicare beneficiaries, due to the centrality of Medicare rates to benchmarks for commercial payers and Medicaid, inadequate Medicare reimbursement has cascading effects across payers.

Given the downward trajectory of Medicare reimbursement, with its frequent reductions and lack of an inflationary update, it is time to stop the significant negative impact of inadequate reimbursement. The Republican and Democratic Doctors Caucuses worked together to introduce the Patients First Act, a comprehensive, bipartisan legislative package that addresses core Medicare payment concerns by:

- Tying Medicare reimbursement to the Medicare Economic Index (MEI): creates predictable, annual increases in Medicare reimbursement.
- Reforming the Merit-based Incentive Payment System (MIPS): introduces the POINTS program that would create the Quality Reform Task Force, reduce MIPS payment penalties, and more.
- Extending Advanced Alternative Payment Model (APM) policies: freezes qualifying APM participant (QP) thresholds and includes new requirements for the CMS Innovation Center (CMMI) models.
- Modernizing antiquated budget neutrality requirements: includes the Provider Reimbursement Stability Act.

We urge the Subcommittee to pass the Patients First Act as a comprehensive package to avoid a series of patchwork policies and enact structural reform.

Provider Reimbursement Stability Act

The Provider Reimbursement Stability Act (H.R. 8163) would make necessary modernizing changes to Medicare's budget neutrality rules that have triggered widespread cuts to physician reimbursement. These broad cuts to Medicare reimbursement are required by statute to offset changes in Relative Value Units (RVUs) over a low threshold that hasn't been updated in decades. For example, important increases to office visit RVUs often result in reimbursement cuts to unrelated procedures. Compounding the negative effects of this low threshold is the fact that erroneous utilization estimates by CMS often lead to these

¹ MGMA Stat, Operating Costs Keep Climbing for Medical Practices in 2026, <https://www.mgma.com/mgma-stat/operating-costs-keep-climbing-for-medical-practices-in-2026>; MGMA Stat, 2026 Medicare Reimbursement Changes: Tracking What Matters, <https://www.mgma.com/mgma-stat/2026-medicare-reimbursement-changes>.

² See Testimony of incoming MGMA Board Chair Jeffrey Smith to the U.S Senate Special Committee on Aging, Feb. 11, 2026, <https://www.mgma.com/advocacy-letters/february-11-2026-mgma-testifies-on-regulatory-burden-and-physician-burnout>.

cuts, yet there is no mechanism in place to correct these errors that undermine the financial stability medical groups. A recent example is CMS' erroneous utilization estimates of HCPCS complexity add-on code G2211 led to significant cuts to Medicare reimbursement. Even after actual utilization data was published and showed significantly lower uptake of the code than CMS predicted, there is no mechanism to return the \$1 billion cut back into the Medicare Physician Fee Schedule.

These rules have destabilized Medicare payment over the years and undermined the ability of medical groups to continue treating Medicare beneficiaries. This bill would make necessary changes such as increasing the budget neutrality threshold and indexing it to inflation. It would also allow for the correction of erroneous utilization estimates of Medicare services to avoid unwarranted cuts. We appreciate the Subcommittee for reviewing this important bill and look forward to working with Congress to pass this critical piece of legislation as part of the Patients First Act discussed above.

Medicare Physician Data-driven Performance Payment System Act of 2026

MACRA replaced the sustainable growth rate formula with the QPP that included two reporting pathways to facilitate the transition to value-based care: MIPS and Advanced APMs. MIPS has been plagued with issues as complying with the program is a time-consuming and laborious process. Medical groups report that the significant program compliance costs associated with MIPS take valuable time and resources away from clinical priorities. The reporting burden is substantial — 86 percent of MGMA members surveyed who participate in MIPS found reporting to lead to increased administrative burden with little clinical benefit.³ “MIPS is especially unworkable,” as one MGMA member succinctly put it in our 2026 survey. Unfortunately, this aligns with what MGMA members have said for years.

MIPS reporting requires clinicians to report on quality measures that are not clinically relevant to their practice. Medical groups often do not know what cost measures they are being scored on, and which patients have been attributed to them. CMS does not provide timely and actionable feedback to allow clinicians to understand and improve their performance. Exacerbating these reporting concerns are the steep payment cuts that medical groups face often due to opaque scoring methodologies and the punitive tournament-style model.

The Medicare Physician Data-driven Performance Payment System Act of 2026 (H.R. 8622) would eliminate MIPS' tournament-style scoring approach that leads to penalties and tie payment adjustments to annual payment updates. It would freeze the current performance threshold to promote stability in the program. Lastly, the bill would ensure CMS provides timely feedback reports and claims data during the performance year. These changes would help mitigate many of the current issues plaguing MIPS. We appreciate the Subcommittee for reviewing this bill and look forward to working with Congress to ensure the MIPS reform measures included in the Patients First Act address the concerns of medical practices.

Conclusion

MGMA sincerely appreciates your attention to reforming Medicare payment. We urge you to pass the above-referenced legislation to remedy years of under-reimbursement and administrative burden, and reinforce group practices' ability to provide high-quality, cost-effective care. If you have any questions,

³ MGMA's 2026 Regulatory Burden Report, Apr. 9, 2026, <https://www.mgma.com/federal-policy-resources/april-9-2026-regulatory-burden-report>.

please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

JEN A. KIGGANS
2ND DISTRICT, VIRGINIA

WASHINGTON, DC OFFICE:
152 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-4602
(202) 225-4215

VIRGINIA BEACH DISTRICT OFFICE:
283 CONSTITUTION DR., SUITE 900
VIRGINIA BEACH, VA 23462
(757) 364-7650



Congress of the United States
House of Representatives
Washington, DC 20515-4602

COMMITTEE ON ARMED SERVICES
SEAPOWER & PROJECTION FORCES

MILITARY PERSONNEL
CYBER, INFORMATION TECHNOLOGIES
& INNOVATION

COMMITTEE ON VETERANS' AFFAIRS

OVERSIGHT & INVESTIGATIONS, CHAIR
HEALTH

COMMITTEE ON NATURAL RESOURCES

WATER, WILDLIFE & FISHERIES
ENERGY & MINERAL RESOURCES

The Honorable Morgan Griffith
Chair
Subcommittee on Health
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

As a healthcare provider, I thank my colleague Rep. LaHood for championing H.R. 1616, the Promoting Access to Diabetic Shoes Act. This bill would allow Nurse Practitioners to prescribe diabetic shoes to Medicare patients who need them, removing the requirement that this can only be done by a physician. H.R. 1616 is supported by 25 national organizations such as the American Diabetes Association, National Rural Health Association, and the American Association of Nurse Practitioners.

As a nurse practitioner, I regularly treated patients with diabetes and was able to order several types of durable medical equipment. But because the diabetic shoes benefit was created outside of the Durable Medical Equipment program, and because Medicare did not yet recognize Nurse Practitioners as providers, once my patient qualified for diabetic shoes, I could no longer continue to treat that patient nor refer the patient directly to a podiatrist or another specialist for the shoes they need. This step has to, under current law, be done by a physician. Diabetic shoes prevent costly, incredibly painful complications such as diabetic ulcers. Forcing a patient to change providers and receive duplicative care ultimately removes patient choice, restricts patient access, and increases costs.

I have been a proud supporter of this bill since before I held federal or state elected office. Prior to serving in Congress, I came to Capitol Hill during fly in season as a Nurse Practitioner advocating for the passage of this very bill. This brief exposure to Washington and the obvious need for subject matter experts in healthcare in Congress inspired me to run for office. I am proud to be here, several years later as a Member of Congress, testifying in support of this bill in front of the Energy and Commerce Committee.

As a former Navy helicopter pilot, geriatric nurse practitioner, and now a Member of Congress, I am capable of speaking up and leading on issues that need change, but as a practicing NP, I can not order a pair of shoes for a patient who needs them. That is nonsensical and must be changed. But this isn't just about me, it is about the over 461,000 nurse practitioners around the nation and the patients in every community who receive care from a nurse practitioner or physician assistant.

Now is the time to remove this outdated barrier to care. Thank you to Rep. LaHood for leading on this important issue, and to the Committee on Energy and Commerce for hearing testimony on the bill.

Jen Kiggans
Member of Congress



AAPA Statement for the Record to the House Energy and Commerce Committee's Subcommittee on Health Hearing: "Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity"

September 15, 2026

Chairman Griffith, Ranking Member DeGette, Chairman Guthrie, Ranking Member Pallone, and Members of the Subcommittee on Health:

On behalf of more than 200,000 physician associates/physician assistants (PAs) throughout the United States, the American Academy of Physician Associates (AAPA) thanks the Subcommittee for holding this hearing and examining legislative proposals to strengthen Medicare and improve access to healthcare for patients across the country.

We also thank Representatives LaHood and Barragán for their leadership in introducing the Promoting Access to Diabetic Shoes Act (H.R. 1616), a commonsense measure that would remove an unnecessary barrier to patient care. While AAPA's primary comments concern H.R. 1616, we appreciate the Committee's consideration of several proposals intended to improve patient access to care, reduce administrative burden, and modernize Medicare to reflect current clinical practice.

As Congress considers reforms to improve Medicare and strengthen patient access to care, AAPA urges the Subcommittee to advance H.R. 1616. Under current Medicare law, a PA may manage a patient's diabetes but cannot certify that the same patient needs therapeutic shoes. H.R. 1616 would correct this inconsistency. This bipartisan legislation would authorize PAs to certify a Medicare beneficiary's need for therapeutic shoes, helping ensure patients receive clinically appropriate care without unnecessary delays or duplicative appointments. Importantly, H.R. 1616 does not alter state scope-of-practice laws or expand the authority of a PA under state law. Rather, it simply aligns Medicare policy with existing state law by ensuring that PAs who are already authorized to manage a patient's diabetes and determine the need for therapeutic shoes may certify that need under the Medicare program.

PAs diagnose and treat illnesses, manage chronic conditions, prescribe medications in all 50 states, and frequently serve as primary care providers for Medicare beneficiaries with diabetes. PAs routinely manage diabetic patients throughout the continuum of care, including monitoring disease progression, addressing complications, coordinating specialty care, and developing treatment plans. For patients with diabetes who are at heightened risk of foot ulcers and other complications, properly fitted therapeutic shoes and inserts can be

an important part of preventive care. Yet under current Medicare law, a PA who manages a patient's diabetes cannot certify that same patient's need for therapeutic shoes. Instead, the patient must obtain certification from a physician, even when that physician is not the clinician who routinely manages the patient's diabetes. This creates unnecessary administrative burden, increases healthcare costs, delays access to preventive care, and disrupts continuity of care.

The restriction is particularly difficult to justify because it does not reflect how healthcare is delivered today. Outside of Medicare, PAs are generally authorized to certify the need for therapeutic shoes for their patients and already possess the clinical expertise necessary to determine when therapeutic footwear is medically appropriate. PAs are federally recognized Medicare providers and are trusted members of healthcare teams in every specialty and practice setting. The lack of authorization under Medicare to certify the need for therapeutic shoes is not consistent with how PAs practice medicine, but rather is an outdated provision of federal law that does not reflect modern healthcare delivery.

Diabetic foot complications are associated with poorer health outcomes, increased healthcare expenditures, and avoidable hospitalizations and amputations. Therapeutic shoes and inserts are an important preventive intervention that can help reduce these risks for Medicare beneficiaries. Congress should ensure that patients are able to obtain these medically necessary services efficiently and without avoidable barriers. The current law requires unnecessary steps in the process without improving patient safety or quality of care.

Research demonstrates that PAs provide high-quality care in the management of diabetes. A study published in *The American Journal of Medicine* found that diabetes management by physician assistants was comparable to management by physicians at diagnosis and during four years of follow-up.¹ Yet the same providers who manage the patient's diabetes remain unable to certify therapeutic footwear intended to reduce the risk of complications associated with that condition under the Medicare program. This inconsistency illustrates the need for Congress to continue examining areas where Medicare policy no longer reflects the realities of contemporary healthcare practice.

The Promoting Access to Diabetic Shoes Act represents a straightforward, bipartisan solution that would improve access to preventive care, reduce unnecessary administrative requirements, support continuity of care, and bring Medicare policy more in line with modern healthcare delivery. These benefits are particularly important in rural and medically underserved communities, where patients often rely on PAs as a principal source of primary care and where unnecessary provider requirements can create significant barriers to care.

AAPA appreciates the Subcommittee's attention to policies that improve access to care for Medicare beneficiaries and stands ready to work with Congress on efforts to modernize Medicare and remove outdated statutory barriers that interfere with timely, high-quality, and cost-effective patient care.

¹ [https://www.amjmed.com/article/S0002-9343\(17\)30904-X/abstract](https://www.amjmed.com/article/S0002-9343(17)30904-X/abstract)

If you have any questions or need additional information, please contact Tate Heuer, VP of Federal Advocacy for AAPA, at theuer@aapa.org or at (517) 319-4338.



September 3, 2026

The Honorable Brett Guthrie
Chairman
House Energy & Commerce Committee
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy & Commerce Committee
2101 Rayburn House Office Building
Washington, DC 20515

The Honorable Jason Smith
Chairman
House Ways & Means Committee
1011 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Ways & Means Committee
372 Cannon House Office Building
Washington, DC 20515

RE: Support for the Alzheimer's Screening and Prevention (ASAP) Act (H.R. 6130/S. 3267)

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Smith and Ranking Member Neal:

As clinician members of the Alliance for Patient Access, we are writing in support of the ASAP Act (H.R. 6130/S.3267). The legislation would modernize Medicare coverage to improve access to early Alzheimer's detection tools.

Founded in 2006, AfPA is a national network of policy-minded health care providers who advocate for patient-centered care. AfPA supports health policies that reinforce clinical decision making, promote personalized care and protect the clinician-patient relationship. Motivated by these principles, AfPA members participate in clinician working groups, advocacy initiatives, stakeholder coalitions and the creation of educational materials. AfPA manages an Alzheimer's Initiative, which convenes providers dedicated to ensuring a patient-centered approach to Alzheimer's disease treatment.

An estimated 7.4 million Americans age 65 and older live with Alzheimer's disease, and that number could nearly double by 2060, underscoring the urgent need for earlier diagnosis and treatment.¹ The disease's toll is already severe: one in three older adults dies with Alzheimer's disease or another dementia. The financial burden is equally significant. In 2026, total payments for health care, long-term care, and hospice services for people living with Alzheimer's or other dementias are projected to reach \$409 billion. Average per-person Medicare payments for beneficiaries with Alzheimer's or other dementias are nearly three times as great as payments for beneficiaries without these conditions. The costs of inaction on Alzheimer's disease to patients, families, and the Medicare program are substantial and growing.

Blood-based biomarker testing represents a significant advance in Alzheimer's diagnosis. In May 2025, the FDA cleared the first blood test for Alzheimer's disease to aid diagnosis in symptomatic patients age 55 and older.² In October 2025, the FDA cleared a second test, specifically for use in the primary care setting to help

¹ <https://www.alz.org/alzheimers-dementia/facts-figures>

² <https://www.fda.gov/news-events/press-announcements/fda-clears-first-blood-test-used-diagnosing-alzheimers-disease>

rule out Alzheimer's-related amyloid pathology.³ As recently as August of this year, an additional test was cleared by the FDA, establishing the first exclusionary and confirmatory blood-based biomarker test for Alzheimer's disease. These tests offer a minimally invasive, more accessible alternative to PET imaging and cerebrospinal fluid testing, both of which are costly, limited in availability, and often require a specialist referral. These clearances reflect a diagnostic field advancing faster than the coverage policies meant to keep pace with it.

These diagnostic advances are especially significant considering new treatment options. In recent years, the FDA has approved several amyloid-targeting therapies that target the underlying biology of Alzheimer's disease and have been shown to slow disease progression in patients with mild cognitive impairment or mild dementia. Both treatments require confirmation of amyloid pathology before they can be prescribed, meaning timely access to biomarker testing is now a prerequisite for patients to be evaluated for these therapies. This evolution in treatment options has been profound, as previous therapeutics for Alzheimer's disease strictly addressed symptomatic concerns.

Beyond current applications, biomedical innovation in Alzheimer's continues to expand. There are now tests and therapies in development that both identify and treat abnormal tau protein accumulation, another of the biological processes that cause Alzheimer's disease.

As the evidence base for blood-based biomarkers continues to grow and additional tests move through the FDA review process, consistent Medicare coverage will be essential to ensuring these tools reach patients in a timely and predictable way, allowing patients to make informed decisions and access appropriate treatment.

Under current law, however, Medicare cannot cover a screening test unless Congress specifically allows for it or the U.S. Preventive Services Task Force recommends it, a process that can take years to complete. The ASAP Act fills that gap, giving HHS the authority and flexibility to ensure that outdated policies do not hinder access to screening, diagnosis and treatment.

Alzheimer's disease is often diagnosed late, after symptoms have already progressed and treatment options are more limited. For Medicare beneficiaries, who make up the population most affected by this disease, reliable coverage of blood-based biomarker testing is critical to identifying patients early, when treatment and lifestyle interventions are most effective.

The ASAP Act would support earlier diagnosis and increased treatment options by:

- Giving HHS greater authority to provide coverage for preventive services
- Allowing Medicare Part B to cover routine, FDA-approved or cleared, blood-tests for Alzheimer's disease and related dementias
- Reducing administrative burden on clinicians and clarifying reimbursement policies

Coverage of these tests can provide additional information that may allow for expedited diagnosis and earlier intervention. This means clinicians can identify at-risk patients earlier in the disease process and explore expanded treatment options, while patients and caregivers gain additional time and information to make decisions about their treatment journey.

³ <https://www.alz.org/news/2025/fda-clearance-blood-test-primary-care-rule-out-alzheimers-related-amyloid-pathology>

It is for these reasons that we urge your support for the ASAP Act, legislation that will help ensure comprehensive biomarker blood test coverage for Alzheimer's disease. If we can provide further details or answer any questions, please reach out to pmarvin@allianceforpatientaccess.org or (202) 951-7097.

Sincerely,

Lealani Mae Acosta, MD, MPH
Vanderbilt Health
Nashville, TN

Alireza Atri, MD, PhD
Banner Health
Sun City, AZ

Allison Batchelor, MD
Geriatric Medicine Consulting
Athens, OH

Corey Bolton, PsyD
Vanderbilt Health
Nashville, TN

Ciaran Considine, PhD
Vanderbilt Health
Nashville, TN

Spencer Diehl, LCSW
Vanderbilt Health
Nashville, TN

Howard Kirshner, MD
Vanderbilt University Medical Center
Nashville, Tennessee

Cara Leahy, DO
Memorial Health
Owosso, MI

Katherine McDonell, MD
Vanderbilt Health
Nashville, TN

Aaron McMurtray, MD
Vanderbilt Health
Nashville, TN

Amalia Peterson, MD
Vanderbilt Health
Nashville, TN

Chase Presley, PhD
Vanderbilt Health
Nashville, TN

Raymond Romano, PhD, MPH
Vanderbilt Health
Nashville, TN

Johannes Schlachetzki, MD
UC San Diego
San Diego, CA

Emily Smith, LCSW
Vanderbilt Health
Nashville, TN

Douglas Terry, PhD
Vanderbilt Health
Nashville, TN

Guiyun Wu, MD
Vanderbilt Health
Nashville, TN

**Statement for Hearing on
“Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster
Health Care Cybersecurity”**

**House Committee on Energy and Commerce
Subcommittee on Health**

September 15, 2026

AHIP is the national trade association representing the health insurance industry. AHIP’s members provide healthcare coverage, services, and solutions to more than 200 million Americans through public programs such as Medicare and Medicaid, employer-sponsored insurance, and the individual insurance market.

Health plans play an essential role in ensuring Americans have access to affordable, high-quality care while safeguarding sensitive health information. Plans work to promote value-based care, negotiate fair and competitive provider reimbursement rates, and invest significant resources in helping to secure patient data and maintain continuity of care.

AHIP appreciates the Subcommittee's interest in examining provider payment policies and cybersecurity safeguards that impact patients, providers, and health plans alike. We are committed to working with the Subcommittee to advance practical solutions that strengthen healthcare affordability and access to high-quality care. Our statement for the record will focus on several of the bills considered before the Subcommittee today.

Prioritizing Healthcare Affordability

As the Subcommittee considers ways to offset the projected costs of physician payment reform proposals, AHIP urges Members to focus on addressing the root causes of the healthcare affordability crisis. Congress should avoid funding mechanisms that would raise premiums and/or reduce benefits for the 36 million beneficiaries who choose Medicare Advantage (MA) because it provides better coverage and better care at lower costs. In fact, MA beneficiaries saved nearly \$1,100 a year in out-of-pocket costs and nearly \$2,100 in insurance premiums compared to a matched set of similar fee-for-service (FFS) Medicare beneficiaries.¹ Seniors who rely on Medicare Supplement (Medigap) coverage to guard against the high costs of standalone FFS Medicare should also be protected.

Financing changes to Medicare’s physician reimbursement system should not result in disruptions to seniors’ choices, costs and benefits. Instead, policymakers should pursue reforms

¹ <https://www.ahip.org/resources/medicare-advantage-leads-to-savings-for-seniors-and-taxpayers>

to make healthcare more affordable. Common-sense policy solutions to address the root causes of the healthcare affordability crisis that have bipartisan support include enacting site-neutral payment policies, stopping the abuses of the pharmaceutical patent system, and fixing the broken surprise billing independent dispute resolution (IDR) process.

Maintaining High-Value Coverage and Cost Savings for Seniors Who Choose MA

AHIP urges policymakers to strengthen and protect MA as a critical choice for 36 million Americans who choose it because it delivers better services, better access to care, and better value than FFS Medicare. As the Subcommittee considers legislation to reform the physician payment system, AHIP encourages Members to avoid policies that would limit MA plans' flexibilities to continue providing high-value coverage and substantial cost savings to 36 million Medicare beneficiaries.

Funding reductions in the MA program would harm seniors who depend on the program by reducing supplemental benefits or increasing premiums. Over half of individuals eligible for Medicare enroll in MA plans. MA plans are highly popular among enrollees, saving them thousands every year compared to standalone FFS Medicare.

Stability in MA is particularly important at this time given that in 2026 MA beneficiaries experienced loss of choices and higher premiums stemming from several years of funding that did not keep pace with higher medical costs and utilization. A study found that 2.9 million enrollees incurred "forced disenrollments" in 2026 due to the reduction of MA options in their areas, and average MA premiums rose 24%.^{2,3} In recent years, the number of beneficiaries covered by MA general enrollment plans has dropped, and the number of plans available to seniors has declined because of federal policies enacted in prior years.

The Subcommittee is also considering several bills that would expand coverage for certain items and services under Medicare FFS. Expanding Medicare FFS coverage of benefits may impact MA plan costs the following year if those changes are made after plans have submitted bids. We urge the Subcommittee to ensure that the implementation dates of new Medicare FFS coverage policies appropriately consider the MA bid cycle, so those changes are incorporated into plan bids.

Protecting Patients from Higher Dental and Vision Care Costs

AHIP is concerned that legislation affecting dental and vision coverage could lead to higher out-of-pocket costs for patients. Consumers value dental and vision coverage not only for insured benefits, but also for the access it provides to negotiated network discounts that help make care

² <https://www.ajmc.com/view/unprecedented-spike-in-plan-exits-threatens-medicare-advantage-stability>

³ <https://www.ahip.org/resources/medicare-advantage-in-2026-fewer-options-higher-costs-due-to-consecutive-years-of-inadequate-rates>

more affordable. Beneficiaries of vision and dental insurance continue to be very satisfied with their plans, driven by easy access to providers and the value they provide.^{4,5}

AHIP is concerned that H.R. 1521, the *Dental and Optometric Care (DOC) Access Act*, could expose patients to significantly higher charges for the same care. Under current law, dental and vision plans provide discounts for care even after an enrollee's annual maximum or other plan limitations have been reached. The bill would prohibit this protection for most dental and vision care and allow providers to charge patients significantly more than their negotiated rate with an insurer.⁶ The result would be higher out-of-pocket costs for dental or vision care, and price sensitive patients may choose to forgo treatment, which can lead to serious adverse consequences for their health.

Additionally, AHIP is concerned that H.R. 1521 would alter existing contractual provisions between dental or vision care providers and insurance carriers. Currently, most provider contracts are evergreen and allow significant flexibility to terminate network participation with notice. The cap on contract terms in H.R. 1521 could create operational challenges and put at risk the progress plans and providers are making in improving network adequacy. In addition, restricting vision plans' ability to direct providers to contracted specialty laboratories could also result in higher costs for patients as providers select more costly alternatives.

As the Subcommittee considers policies affecting dental and vision coverage, AHIP urges policymakers to prioritize patient access to affordable dental and vision care by preserving negotiated discounts, maintaining robust provider networks, and delivering high-value benefits.

Conclusion

AHIP thanks the Subcommittee for its attention to these important issues. We look forward to working collaboratively with the Subcommittee to identify and implement common-sense, market-based policies that improve affordability, promote competition and transparency, strengthen care coordination, and enhance the resilience of the healthcare system.

⁴ <https://www.ahip.org/resources/ahip-dental-insurance-satisfaction>

⁵ <https://www.ahip.org/resources/vision-insurance-satisfaction>

⁶ <https://www.healthpartners.com/blog/is-dental-insurance-worth-it/>

Representative Jim Costa (CA-21)

House Committee on Energy & Commerce: Subcommittee on Health

Statement: *Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity*

September 15, 2026

Thank you to the Committee for considering H.R. 1189 - National Plan for Epilepsy Act and for the opportunity to submit this statement for the record. I introduced this bipartisan legislation with Congressman Greg Murphy to strengthen our nation's response to epilepsy and improve the lives of individuals and families affected by this condition. I urge the Committee to advance this important legislation.

Epilepsy affects approximately three million adults and more than 450,000 children in the United States. For many, the challenges extend beyond managing seizures. People with epilepsy can face difficulty finding a specialist, affording medications, and securing transportation to medical appointments. Families should not have to navigate these barriers alone, and where someone lives or how much they earn should not determine whether they receive the care they need.

This issue matters deeply to families in the San Joaquin Valley. Valley Children's Healthcare, which supports this legislation, has emphasized the importance of research, new treatments, and access to specialized care for children with epilepsy, including those from low-income families. We must support that work and ensure that advances in treatment reach the patients who need them.

My commitment to this effort has also been shaped by my mentor, former Congressman Tony Coelho, and his lifelong advocacy for people with epilepsy. His leadership reminds us that improving medical care and fighting stigma must go hand in hand. People with epilepsy deserve the opportunity to participate fully in their schools, workplaces, and communities.

The House legislation would direct the Department of Health and Human Services to establish and maintain a national plan to improve epilepsy prevention, diagnosis, treatment, and research. It would bring federal agencies together with patients, caregivers, health care providers, and researchers through an advisory council, while requiring regular assessments and reports to Congress. Its priorities include improving access to specialized care, supporting the development of better treatments, reducing disparities, and preventing sudden unexpected death in epilepsy and other epilepsy-related deaths.

The goal is straightforward: better coordination, clearer priorities, and accountability for results. We should make sure federal efforts are working together and that the experiences of patients and families help guide our decisions. A parent caring for a child with epilepsy or an adult struggling to find effective treatment should have a meaningful voice in shaping that response.

The Senate took an important step on August 4 by passing an amended version of the National Plan for Epilepsy Act, S. 494, by unanimous consent. That legislation would require a review of existing federal epilepsy efforts, input from patient advocates and other experts, and recommendations to

Congress on improving coordination, research, and care. This progress gives us an opportunity to work across both chambers and move legislation toward enactment.

I thank Congressman Murphy, Senators Eric Schmitt and Amy Klobuchar, the Epilepsy Foundation, and the patients, families, and advocates who have helped build support for this effort. Improving the lives of people with epilepsy is a goal we can pursue together, regardless of party.

I respectfully urge the Committee to move the National Plan for Epilepsy Act forward following this hearing and work with us to bring it before the full House. Families living with epilepsy deserve a sustained national commitment to better care, better treatments, and ultimately a cure. Thank you for your consideration.

September 14, 2026

The Honorable Brett Guthrie
Chairman
House Committee on Energy and Commerce

The Honorable Morgan Griffith
Chairman
Health Subcommittee
House Committee on Energy and Commerce

The Honorable Frank Pallone
Ranking Member
House Committee on Energy and Commerce

The Honorable Dianna DeGette
Ranking Member
Health Subcommittee
House Committee on Energy and Commerce

RE: September 15, 2026, Subcommittee on Health Hearing *Examining Legislative Proposals to Reform Medicare provider Payment and Bolster Health Care Cybersecurity*

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Griffith and Ranking Member DeGette,

The undersigned organizations representing patients and health care providers write to express our strong support for H.R. 1616, *Promoting Access to Diabetic Shoes Act* which would authorize nurse practitioners (NPs) and physician associates/physician assistants (PAs) to certify when patients with diabetes meet the criteria for therapeutic shoes.

Currently in Medicare, patients with diabetes who see an NP or PA must undergo a multistep process to obtain medically necessary therapeutic shoes. When the treating NP or PA determines that the patient has a condition requiring therapeutic shoes, the NP or PA must send the patient to a physician to make the same determination and take over the patient's care related to diabetes. The physician then refers that patient to a "podiatrist or other qualified individual" to fit and furnish the shoes. This process requires an additional billable visit and delays patient access to effective treatment for complications related to diabetes.

For patients in rural and underserved communities who face challenges in accessing care, this barrier may be the difference between receiving or foregoing care. Diabetic shoes are a proven treatment method to prevent further comorbidities and complications, and early intervention helps prevent costly complications. The barriers to care which delay patients receiving these necessary preventative services lead to costly complications.

Utilization of therapeutic footwear is effective for the prevention of diabetic foot ulcers (DFUs) in at-risk patients with diabetes.^{1,2} The risk for patients is steadily increasing, as approximately 1.6 million people have DFUs, which are associated with increased rates of amputations and mortality.³ Up to one-third of

¹ Bus, S.A., van Netten, J.J., Lavery, L.A., Monteiro-Soares, M., Rasmussen, A. & Jubiz, Y., Price, P.E. (2016). IWGDF guidance on the prevention of foot ulcers in at-risk patients with diabetes. *Diabetes/Metabolism Research and Reviews*, 32(Suppl.1), 16-24. doi: 10.1002/dmrr.2696

² American Diabetes Association. (2018). Standards of Medical Care in Diabetes-2018. *Diabetes Care*, 41, 917-928 . <http://care.diabetesjournals.org/content/diacare/early/2018/03/20/dci18-0007.full.pdf>

³ Armstrong, D.G., Tze-Woei, T., Boulton, A.J. & Bus, S.A. (2023). Diabetic Foot Ulcers: A Review. *JAMA*, 330(1), 62-75. doi: 10.1001/jama.2023.10578

the costs of diabetes care are for DFUs and other lower-extremity complications.⁴ The number of diabetes-related hospitalizations due to lower limb amputations (LLAs) doubled from 2009-2019 and 87% of LLAs are a result of complications from diabetes.^{5,6} The proportion of LLAs attributable to diabetes is highest for people ages 45-74.⁷

It is important to note that while this legislation would authorize NPs and PAs to certify their patients' need for therapeutic shoes, it does not change the criteria necessary for coverage. The certifying clinician will still be required to affirm a patient meets the existing Medicare criteria required to certify their need for shoes. Medicare's policy benefit manual clearly delineates that a patient must have one or more of the following conditions: peripheral neuropathy with evidence of callus formation; history of pre-ulcerative calluses; history of previous ulceration; foot deformity; previous amputation of the foot or part of the foot; poor circulation.⁸ These requirements will not change because of this legislation.

Within the recently released Long-Term Enhanced ACO Design (LEAD) Model, the Centers for Medicare and Medicaid Innovation (CMMI) recognized the impact of this barrier on the Medicare program. Utilizing statutory flexibilities to test CMMI models, LEAD authorizes NPs and PAs to certify their patients' need for therapeutic diabetic shoes. CMMI states that removal of this barrier is "is expected to reduce delays in patients accessing this benefit and avoid the costs of an additional clinician visit."⁹ CMMI states that waiving this barrier is expected to "limit Medicare expenditures by providing a streamlined approach for certifying and ordering care, avoiding duplicative work."¹⁰ This waiver was also included within CMMI's ACO REACH model.¹¹ The agency notes that empowering NPs/PAs "would capitalize on established relationships between a beneficiary and a NP to reduce impediments to better coordinate care for beneficiaries and bridge potential gaps in coverage."¹²

Passage of H.R. 1616 addresses this issue and will make it possible for NPs and PAs to continue providing high-quality care to their Medicare patients with diabetes. It will also reduce Medicare spending by eliminating duplicative services, improving the timeliness of care for patients with diabetes who need therapeutic shoes, and allowing patients to continue receiving care from their provider of choice.

We greatly appreciate the health subcommittee's consideration of this bill in this legislative hearing and look forward to the full committee's consideration. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

Alliance of Wound Care Stakeholders

American Academy of Nurse Practitioners Certification Board

American Academy of Nursing

American Academy of PAs

⁴ Armstrong, D.G., Swerdlow, M.A., Conte, M.S., Padula, W.V. & Bus, S.A. (2020). Five year mortality and direct costs of care for people with diabetic foot complications are comparable to cancer. *Journal of Foot and Ankle Research*, 13(16). <https://doi.org/10.1186/s13047-020-00383-2>

⁵ CDC. (2024). Preventing Diabetes-Related Amputations. <https://www.cdc.gov/diabetes/diabetes-complications/preventing-diabetes-related-amputations.html> CDC_AAref_Val=<https://www.cdc.gov/diabetes/library/features/amputations.html>

⁶ CDC. (2021). Diabetes State Burden Toolkit. <https://nccd.cdc.gov/Toolkit/DiabetesBurden/Hospitalization/Lea>

⁷ Ibid

⁸ <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf>

⁹ [lead-rfa.pdf](#)

¹⁰ Ibid

¹¹ [ACO Realizing Equity, Access, and Community Health \(REACH\) Model Request for Application](#)

¹² Ibid

American Association of Nurse Practitioners
American Diabetes Association
American Organization for Nursing Leadership
American Nephrology Nurses Association
American Nurses Association
American Society of PeriAnesthesia Nurses
diaTribe
Gerontological Advanced Practice Nurses Association
Hospice and Palliative Nurses Association
Kroger
National Association of Indian Nurses of America
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Association of Rural Health Clinics
National League for Nursing
National Organization of Nurse Practitioner Faculties
National Rural Health Association
Nurses Organization of Veterans Affairs
Organization for Associate Degree Nursing
PA Education Association
Preventive Cardiovascular Nurses Association

Opening Statement
As Prepared for Delivery
Rep. Diana DeGette
Committee on Energy & Commerce
Health Subcommittee Hearing: “Examining Legislative Proposals
To Reform Medicare Provider Payment And Bolster Health Care
Cybersecurity”
September 15, 2026

Sure as the sun rises, this Committee’s majority continues to fail to meet the moment.

Health care costs are soaring.

Two children and an adult in Pennsylvania have died of measles, paying the ultimate price for getting a preventable disease.

The largest cyclospora outbreak in our nation’s history, which scared millions of Americans off eating vegetables, is just ending.

All this because Donald Trump and RFK Jr. are destroying our public health system, and all this without a word from this majority.

Following the passage of the Big Bad Bill, which Americans know is causing higher prices and less care, this Committee’s approach to health policy has been malign neglect.

Russ Vought and Jay Bhattacharya cut millions of dollars worth of grants for biomedical research, then try to turn money for NIH over to the Pete Hegseth and the Department of Defense—nothing.

RFK Jr. posts lies about vaccines on the CDC website and then appoints a doctor who makes money selling unproven treatments to children with autism to be the nation's top children's health researcher—silence.

And Donald Trump doubles down on the cruelty of the Big Bad Bill, going further to shut off funding for care for the nation's most vulnerable than even the Republicans on this committee intended—not a peep.

Since the beginning of this Congress, Democrats have routinely called for this Committee to do real work, and we have been walking the walk.

We have sent dozens of oversight letters to the administration.

We have put forth real legislative solutions to bring down costs and improve care.

And we have implored this Committee to have hearings about the real problems facing the American people—including on

Ebola, measles, biomedical research, drug pricing, the destruction of our nation's public health system—I could go on.

I don't want to say we have done no good work this Congress.

Several of my bills have been signed into law, including the Preventing Maternal Deaths Reauthorization Act and the PREVENT DIABETES Act.

But without Elon Musk tweeting and scaring off every Republican who supported the package, they would have been done in December 2024,

We proceeded to waste a year trying to finish those bills that everyone already agreed on.

And we're still not finished—the Pandemic and All-Hazards Preparedness Act, or PAHPA, is still lapsed, and there is no reauthorization in sight.

The bills before us today are worthy of our consideration.

In particular, I'm glad we are finally taking up real reforms to the Medicare Physician Fee Schedule, and I want to congratulate my colleagues Dr. Joyce and Dr. Schrier for their great work in building a realistic bill that I hope and believe has a path to eventual passage.

And my bill with Dr. Joyce, the Diabetes Foot Health Access and Modernization Act, will make it easier for Medicare beneficiaries with diabetes to get the specialized shoes they need to prevent foot ulcers and ultimately amputations.

But while I do support these bills, we are not meeting the moment.

This committee urgently needs to turn its attention to rebuilding the public health system, bringing down health care costs, and ensuring that the best biomedical research in the world still happens right here in the U.S.

I know it's silly season, 7 weeks before an election.

But my constituents can't afford silly season. None of ours can.

We must turn from negligence and towards thoughtfulness, constructiveness, and seriousness.

I yield the balance of my time.

**Statement for the Record
by the
Primary Care Collaborative
for the
House Committee on Energy and Commerce
Subcommittee on Health
on
“Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster
Health Care Cybersecurity”**

September 15, 2026

Thank you for the opportunity to submit this statement on behalf of the Primary Care Collaborative (PCC) regarding the first item on the agenda: H.R. 9693, the Patients First Act of 2026.

The PCC is a nonprofit, nonpartisan coalition of 66 organizational members, including clinicians, patient advocates, employer groups, and health plans. The PCC and its members are dedicated to a high-quality health care system rooted in whole-person primary care, with a focus on comprehensive, ongoing relationships and addressing underlying factors to improve patient experience and health outcomes. The PCC launched the Better Health Now campaign in 2022 as a broad-based effort led by diverse PCC members to enact federal policy changes that will improve Americans’ health by expanding access to primary care.

PCC and our Better Health NOW Campaign have expressed our support for the Patients First Act. The PCC appreciates the bipartisan leadership reflected in the legislation and supports the legislation's efforts to modernize Medicare physician payment, strengthen patient access to care, and provide greater stability and flexibility for primary care practices. We believe these reforms are important steps toward a Medicare payment system that better recognizes the value of primary care, care coordination, prevention, behavioral health integration, and other high-value services that patients need. This statement focuses on the hybrid primary care payment model detailed in section 102 of HR 9693, articulates its importance to the nation’s health and **offers specific recommendations to strengthen the bill as it moves through the legislative process.**

Primary Care as the Foundation of the Health Care System

Research has consistently demonstrated that primary care is the foundation of an effective health care system. Primary care clinicians are often the first point of contact for patients and serve as trusted partners in prevention, chronic disease management, care coordination, and

navigation across the health care system. Strong primary care is associated with better health outcomes, lower mortality, and greater life expectancy at similar or lower total costs.ⁱ

Yet the United States continues to underinvest in primary care. Primary care accounted for only approximately 4.5 percent of total U.S. health care spending in 2023, down from 5.4 percent in 2012.ⁱⁱ This longstanding underinvestment has consequences for patients and clinicians alike, contributing to workforce challenges, limited access, and growing pressure on primary care practices to provide more comprehensive services with insufficient resources.

The problem is particularly acute for practices whose patient panels have complex health and social needs, requiring management over time to prevent avoidable complications. Primary care clinicians frequently coordinate among specialists, hospitals, pharmacies, behavioral health providers, community-based organizations, and other services. Medicare payment policy should recognize and support this work.

Modernizing Medicare through Hybrid Payment

For decades, fee-for-service payment has placed primary care at a structural disadvantage by emphasizing individual discrete services, rather than the relationships and team-based care that are central to comprehensive primary care. We are grateful that Congressional leaders have recognized that building on the current fee-for-service system will not advance the structural reforms necessary to improve the health of the nation. H.R. 9693 takes important steps toward addressing these longstanding shortcomings.

The legislation would establish a five-year demonstration creating a hybrid payment approach for eligible primary care clinicians, combining traditional fee-for-service payments with prospective per-member-per-month payments. **This approach has significant potential to provide primary care practices with the predictable resources necessary to invest in care teams, care management, behavioral health integration, technology, and other infrastructure that supports comprehensive, patient-centered care.** The model as designed includes critical provisions to ‘except budget neutrality’ as in, letting the payments for model services proceed outside of the restrictions of budget neutrality, for the years of the model, both preserving the principles of the model as independently evaluable, and avoiding the evitable external conflicts that arise within the confines of a budget neutral construct.

The PCC has long championed hybrid payment for primary care because it provides practices with greater predictability, sustainability, and flexibility to best meet patient needs. Practices can craft a high-quality team-based approach for the patient, that treats the whole person and their needs, while at the same time preserving appropriate fee-for-service

payments for services that should be incented or are not regularly delivered across primary care practices.

Tests of prospective payments have proven that predictable up-front payments allow practices to build capacity, add talent to teams, and improve the quality of care. The Centers for Medicare and Medicaid Services (CMS) has tested and repeatedly leveraged up-front investments at the Innovation Center (CMMI) with nearly all models receiving infrastructure or pre-implementation funding, and a number of model designs including recurring prospective payments (i.e., ACO REACH, PC Flex, Primary Care First, Advance Payment ACO, ACO Investment, CHART, MCP, AHEAD, LEAD, KCC, Maryland Primary Care, Vermont All-Payer ACO, etc.).ⁱⁱⁱ

The Patients First Act's primary care provisions recognize that some of the most important primary care services cannot be adequately supported through traditional fee-for-service billing. **Care management, behavioral health integration, patient outreach, follow-up communications, and other activities that provide continuity and longitudinal care to help patients remain healthy and avoid unnecessary utilization often require time and resources that are not captured accurately by individual encounters.** Without access to prospective payments, practices find it more difficult to plan, invest, recruit and retain clinicians, and maintain access to care. Independent and community-based practices and those providing safety net care are disproportionately impacted when payment does not adequately reflect the cost and value of delivering primary care.

By providing prospective funding for hybrid model activities, the demonstration could give primary care practices greater capacity to deliver whole-person care and develop the primary care teams that patients and communities deserve.

Hybrid Model Eligibility for Success

While the PCC supports the proposed hybrid payment demonstration, **we believe the legislation should be carefully structured to ensure that it generates meaningful evidence about how prospective primary care payment can improve outcomes for diverse Medicare populations.**

As currently drafted, eligibility limitations could prevent participation from practices serving patients in academic medical centers, community health centers, other safety-net settings, and independent primary care practices that participate in ACOs or clinically integrated networks that engage with private payers. As a result, **the narrowly drawn eligibility limitations could effectively exclude some of the more complex Medicare beneficiaries, including beneficiaries who are dually eligible for Medicare and Medicaid.** The most complex Medicare beneficiaries often have the greatest need for coordinated, longitudinal primary care.

They may require behavioral health services, social supports, specialty care, medication management, and coordination across multiple settings.

These patients and practices should not be left out of a demonstration because any future application of this payment methodology would benefit from a test that includes a cross-section of patient populations and practice types. Similarly, independent practices that participate in accountable care organizations or other value-based arrangements should not inadvertently be excluded simply because of their organizational structure.

The PCC encourages Congress and CMS to examine these eligibility provisions carefully as the legislation advances. A successful hybrid model demonstration should serve and generate evidence across a broad range of patients and practice settings, including those serving rural, underserved, medically complex, and historically under-served populations.

Eliminating Cost-Sharing in the Hybrid Model

The PCC also supports the bill's elimination of beneficiary cost sharing in the hybrid model. Cost-sharing creates unnecessary barriers to high-value care. Patients may delay or forgo preventive services, care management, behavioral health services, or follow-up care when they face out-of-pocket costs, even when those services can help prevent more serious and expensive health problems later. The Patients First Act would address this barrier within the proposed primary care demonstration by waiving beneficiary cost-sharing for covered services included in the per-member-per-month bundle.

Reducing financial barriers to care shifts Medicare toward a system that invests in upstream prevention rather than waiting until patients require more intensive and costly intervention – providing excellent government ROI.^{iv} Eliminating the barrier of cost sharing is particularly important for care management and integrated behavioral health services. These services help patients manage chronic conditions, address mental health and substance use disorder needs, coordinate care across settings, and intervene earlier when health problems arise.

As the PCC shared in a Statement for the Record for the House Committee on Energy and Commerce Subcommittee on Health May 20, 2026, hearing *Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reform*, **cost-sharing creates unnecessary challenges for clinicians and patients – causing administrative friction and placing needless financial burdens on accessing high-value primary and preventive care.**^v

Strengthening Behavioral Health Integration

Behavioral health integration is another important component of comprehensive primary care and an area where the legislation could be further strengthened. Primary care clinicians

routinely identify and address behavioral health needs, and connect patients to other behavioral health professionals, yet this whole-person approach may not fit neatly within traditional fee-for-service payment structures.

The proposed hybrid model creates an opportunity to support greater integration of behavioral health into primary care, but the legislation as drafted lacks information on services included within the prospective payment bundle, and outside the bundle. **Whether in future drafts, report language, or agency guidance, further clarification of behavioral health services included in the model should be provided, with assurance that payment for services outside the bundle remain separately and appropriately billable.**

A well-designed demonstration will yield the strongest test results, and help primary care practices build integrated teams and make behavioral health services more accessible while recognizing the full value of services that require specialized expertise.

The Congressional Responsibility to Invest in Primary Care

Investments to strengthen primary care should be seen not as expenditures, but as opportunities for short and long term gains in financial savings for Americans, better quality of health services, and improved future health outcomes for patients. Evidence from Medicare and accountable care models has found that organizations with stronger primary care capacity generate larger savings and improve care more effectively.^{vi} By avoiding preventable hospitalizations, managing chronic conditions, coordinating follow-ups, and providing whole-person services in lower-cost community settings, primary care practices are a practical and logical investment. As the Medicare program confronts long-term spending pressures, Congress and official actuarial scoring of this legislation should factor in the downstream consequences of inadequate investment in primary care and potential for future savings with proper investment.

Quality Reform Task Force Representation

While the Quality Reform Task Force represents an effort to improve and standardize measures, the PCC believes that patient perspectives should be represented in this process. As a multistakeholder organization, the PCC has seen the value of bringing patients, clinicians, employers, health plans, and other stakeholders together to develop policies that reflect the realities of the health care system. Patient representation on the Quality Reform Task Force would strengthen the process and help ensure that quality measurement remains focused on what matters most to the people receiving care.

Recommendations

The PCC respectfully recommends that Congress focus make the following three improvements to the Patients First Act:

1. **Clarify the eligibility for the hybrid model to ensure that model eligibility does not focus on the largest or most highly resourced organizations.** Eligibility and implementation should allow independent practices and other safety net providers to participate meaningfully, including practices that participate in accountable care organizations.
2. **Increase specificity in the bill or subsequent materials around behavioral health services to be included in the hybrid model and those to remain separately billable outside of the PMPM at their full value.**
3. **Add patient representation to the Quality Reform Task Force to ensure meaningful representation** and improved measurements that reflect outcomes and experiences that matter to beneficiaries.

Conclusion

The United States cannot achieve a high-value, patient-centered health care system that cares for a whole person and provides longitudinal and high-quality care, without a strong foundation of primary and preventive care. Primary care clinicians are the backbone of prevention, chronic disease management, care coordination, behavioral health integration, and continuous care relationships that keep our country healthy. Yet Medicare pricing has historically undervalued these activities with inadequate investment in teams and infrastructure required to deliver comprehensive care. **H.R. 9693 the Patients First Act of 2026 represents an important step toward stronger primary care and better health for American families and communities.**

The PCC especially supports Congress' efforts to establish a hybrid primary care payment model, reduce cost-sharing barriers to high-value services, provide budget neutrality, modernize quality measurement, and address longstanding structural problems in Medicare payment. At the same time, legislators have an opportunity to strengthen the legislation by ensuring that the hybrid model reaches complex and underserved beneficiaries, that independent and community-based practices can participate, that behavioral health integration is appropriately supported, and that patients have a meaningful voice in quality reform.

The PCC and its 66 member organizations stand ready to work with Congress, CBO and CMS to advance policies that strengthen primary care, improve access and outcomes for Medicare beneficiaries, and support a high-value health care system.

Thank you for including our perspective in the record. Any questions may be directed to Senior Director of the Better Health NOW campaign – Katie Comando at kcomando@thepcc.org

ⁱ Centers for Medicare & Medicaid Services, “The CMS Innovation Center’s Strategy to Support High-Quality Primary Care,” June 9, 2023.

^{ii 4} Primary Care Collaborative. (2025). Make Medicare Beneficiaries Healthier by Strengthening Primary Care. <https://thepcc.org/wp-content/uploads/2025/03/Make-Medicare-Beneficiaries-Healthier-Issue-Brief.pdf>

ⁱⁱⁱ Centers for Medicare & Medicaid Services (CMS), <https://www.cms.gov/priorities/innovation/about>

^{iv} Pollack, A. A., Ricci, D. A., Song, Z., Sullivan, E. E., Grumbach, K., Cohen, D. J., Phillips, R. S., & Primary Care Collaborative. (2025). *The Primary Care Investment Guide*.

^v U.S. Congress, House Committee on Energy and Commerce Subcommittee on Health, Ann Greiner, Statement for the Record, 119th Cong., 2nd session, 2026, vol. 172, No.86, page:D540.

<https://thepcc.org/wp-content/uploads/2026/05/PCC-SFTR-5.20.26-EC-MACRA-hearing-FINAL.pdf>

^{vi} Gao J, et al., “The Effect of Primary Care Visits on Total Patient Care Cost,” *Journal of General Internal Medicine* (2022).



Written Testimony of Bridget Pfaff, M.S.

Clinical Operations Director, Emplify Health by Gundersen

President, Renal Healthcare Association Board of Directors

Submitted to the U.S. House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

Hearing on "Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity"

In Support of H.R. 6214, the Kidney Care Access Protection Act

September 15, 2026

Chairman Griffith, Ranking Member DeGette, and distinguished members of the Subcommittee: on behalf of the Renal Healthcare Association (RHA), thank you for the opportunity to submit this statement for the record in strong support of H.R. 6214, the Kidney Care Access Protection Act, introduced by Representatives Carol Miller (R-WV) and Terri Sewell (D-AL), with companion legislation (S. 2730) introduced in the Senate by Senators Marsha Blackburn (R-TN) and Cory Booker (D-NJ).

My name is Bridget Pfaff, and I serve as Board President of the Renal Healthcare Association (RHA), representing independent dialysis facilities across the country. I am also the Clinical Operations Director at Emplify Health by Gundersen, where I oversee dialysis operations in Southwest Wisconsin. Over my more than 30-year career, I have supported patients in rural communities in roles ranging from entry-level positions to clinical leadership. My connection to kidney disease is also personal: my grandmother was diagnosed with a familial form of chronic kidney disease (CKD) known as polycystic kidney disease (PKD), and I witnessed firsthand the meaningful difference that effective dialysis care makes for patients and families.

RHA is a member-based trade organization representing over 150 dialysis providers nationwide that deliver life-sustaining dialysis services to nearly 135,000 Medicare beneficiaries. Our membership is composed primarily of small and independent for-profit and not-for-profit providers serving patients in urban, rural, and suburban communities, in both free-standing and hospital-based facilities. These providers disproportionately serve rural and disadvantaged populations. An RHA-commissioned analysis found that small, medium-sized, independent, and hospital-based providers comprise nearly all

dialysis groups (97 percent) serving the highest concentration of low-income beneficiaries.¹ RHA and its members strongly support access for all patients to innovative drugs, devices, and technologies that improve clinical outcomes and quality of life for individuals living with ESRD.

Why This Bill Is Urgently Needed

End-Stage Renal Disease (ESRD) is the last stage of CKD and is characterized by permanent, irreversible kidney failure. ESRD. Approximately 70 percent of individuals with ESRD rely on maintenance dialysis to survive.² Because dialysis is delivered under a Medicare bundled prospective payment system (ESRD PPS), the accuracy and adequacy of that payment structure directly determine whether facilities can keep their doors open, particularly for small and independent providers with narrow operating margins.

Rising costs for staff, supplies, and equipment are outpacing Medicare reimbursement updates, and facility closures may be accelerating. Prior to 2020, roughly 50 to 70 dialysis facilities closed annually.³ An RHA-commissioned analysis identified nearly 200 closures in 2022 alone, and MedPAC has reported declines in rural dialysis capacity since 2022.⁴ According to RHA-commissioned analysis of Medicare cost report data from 2017 to 2024, labor costs per treatment rose by over 28 percent and supply costs rose by almost 18 percent, while cumulative ESRD PPS base rate updates over that period totaled just 17 percent.⁵ The evidence of that underlying inadequacy is well documented.

For small and independent providers, including many RHA members, the gap between reimbursement and actual costs is particularly acute. These facilities often operate with fewer treatment stations and lack the scale and competitive advantages of larger organizations. This financial strain is contributing to facility closures, which can disrupt care and reduce access for patients. In 2024, freestanding facilities in the lowest quintile of treatment volume had an aggregate fee-for-service margin of negative 11.6 percent, even as the overall industry margin improved.⁶ When a dialysis facility closes, patients must travel farther, adjust treatment schedules, or transfer care. These disruptions can

¹ Based on study by Dobson DaVanzo & Associates commissioned by RHA analyzing 2020 Medicare claims for ESRD Treatment Choices (ETC) model participants. Low-income beneficiaries were defined as dually eligible for Medicare and Medicaid and receiving the Part D Low Income Subsidy. Highest concentration dialysis groups were those serving the highest decile (over 63 percent of their Medicare patient panel) of low-income beneficiaries.

² MedPAC, Report to Congress, March 2025, Chapter 5, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch5_MedPAC_Report_To_Congress_SEC.pdf.

³ Analysis of Medicare's Dialysis Facility Care Compare (DFCC) database between 2017 and 2023 by Prima Health Analytics, Weymouth, MA. Prepared for RHA in May 2024.

⁴ MedPAC, Health Care Spending and the Medicare Program, July 2025.

⁵ Analysis of 2017-2024 Medicare Cost Reports conducted for Renal Services Exchange.

⁶ MedPAC Report to Congress, March 2026, Chapter 5, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf

negatively affect health outcomes for an already medically fragile population. Targeted, bipartisan legislative solutions like H.R. 6214 are necessary to preserve small, independent dialysis facilities and protect patient access to these critical services.

H.R. 6214 Addresses Critical Gaps in ESRD Payment Policy

While H.R. 6214 also includes important provisions to strengthen kidney disease screening and patient education under Medicare, RHA's testimony focuses on the bill's payment adequacy provisions, which are most directly relevant to the financial stability of the dialysis facilities our members represent.

1. Correcting for Forecast Error in the ESRD Market Basket

RHA has consistently urged the Centers for Medicare & Medicaid Services (CMS) to provide a one-time, non-budget neutral base rate adjustment. The ESRD PPS base rate remains too low to reflect the actual cost of furnishing dialysis care, a concern that is distinct from, and not resolved by, the size of any single year's update. However, accurate annual updates are an essential part of establishing and maintaining sufficient rates.

H.R. 6214 would require CMS to apply a forecast error adjustment to the annual ESRD PPS market basket update whenever the difference between projected and actual cost growth exceeds 0.5 percentage points, consistent with the forecast error adjustment already applied to Skilled Nursing Facilities. Current annual updates are based on projected cost growth that has sometimes understated the actual cost increases providers face for labor and supplies. Without a corrective mechanism, these forecasting errors compound year over year, potentially widening the gap between payment and the true cost of care and placing sustained financial pressure on small and independent facilities that lack the scale to absorb it. While RHA has also urged CMS to adopt this policy administratively, codifying this adjustment in statute would provide a more permanent fix and give facilities the payment stability needed to remain open and continue serving patients.

2. Extending Transitional Add-on Payment Adjustment for Innovative Therapies

H.R. 6214 would extend the Transitional Drug Add-on Payment Adjustment (TDAPA) and the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) from the current two-year periods to at least three years. It would also establish a permanent post-TDAPA add-on payment for qualifying drugs and biologics rather than fully absorbing them into the ESRD bundle without adequate adjustment.

Providers face challenges in adopting newer treatments and technologies. Payment and coverage policies do not always keep pace with innovation, making it difficult for providers to incorporate new therapies into patient care. In some cases, there are delays or uncertainty around reimbursement for new drugs, equipment, and supplies, which can limit their availability in clinical practice. Providers also report challenges continuing to offer these treatments after the TDAPA or TPNIES payments expire. This results in patients facing barriers to newer treatment options that could improve outcomes and quality of life. H.R. 6214 responds directly to this documented and growing problem.

One example of how these temporary add-on payments do not currently support use beyond initial adoption is Korsuva, a drug administered during dialysis treatments, which providers report costs facilities approximately \$1,700 per patient per month. Under CMS's current post-TDAPA payment methodology, providers report receiving only about \$125 per month in additional reimbursement for a facility treating 100 patients, far short of the actual cost of furnishing the drug. When innovative therapies transition out of TDAPA and TPNIES status before the bundle base rate has been recalibrated to reflect their true cost, facilities are forced to either absorb substantial losses or limit access to these therapies. Small and independent providers, which lack the purchasing leverage and financial reserves of larger organizations, are disproportionately exposed to this risk. Extending the transitional payment period and creating a permanent post-TDAPA add-on would give CMS the time and payment tools necessary to set an accurate, sustainable long-term payment rate, helping to ensure that innovation reaches patients without threatening the financial viability of the facilities that furnish it.

3. Ensuring Medicare Advantage Parity with Traditional Medicare for Innovative Therapies

H.R. 6214 would require CMS to make direct payment adjustments for Medicare Advantage (MA) enrollees to providers and facilities consistent with the TDAPA and TPNIES payments available under fee-for-service Medicare. RHA members report that some MA plans resist or delay separate payment for TDAPA- and TPNIES-eligible therapies, misunderstand that these payments are separate from the bundled base rate, or impose utilization management requirements exceeding those required under Traditional Medicare. This results in challenges for dialysis facilities to furnish new and innovative therapies to MA-enrolled patients, potentially limiting access to clinically appropriate treatment options. As enrollment among beneficiaries with ESRD continues to grow in MA, this provision in H.R. 6214 becomes increasingly important to ensure that innovative treatment options remain available to all beneficiaries, regardless of their coverage model.

Conclusion

RHA member facilities are deeply rooted in the communities they serve, often continuing to operate in areas where other providers have consolidated, downsized, or exited the market altogether. In many rural and underserved regions, these independent facilities are the only local access point for life-sustaining dialysis care. H.R. 6214 offers a targeted and bipartisan approach to preserve that access by correcting the compounding effect of forecast error in annual payment updates, extending transitional payment periods so innovative therapies reach patients without financial risk to the facilities that furnish them, and providing the same payment support for those innovative therapies for enrollees in MA as those in Traditional Medicare. H.R. 6214 would meaningfully strengthen the stability of the ESRD Medicare benefit and support patient access to life-sustaining dialysis care, without disrupting the underlying bundled payment structure that Congress established.

On behalf of the RHA and the independent and community-based providers we represent, we respectfully urge the Subcommittee to advance H.R. 6214. We thank the Subcommittee for convening this hearing and for its continued attention to the policies that determine whether patients with ESRD can continue to receive life-sustaining care close to home. We urge the Committee to mark up the legislation and stand ready to serve as a resource as this legislation moves forward.