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6 EXAMINING LEGISLATIVE PROPOSALS TO REFORM MEDICARE

7 PROVIDER PAYMENT AND BOLSTER HEALTH CARE CYBERSECURITY

8 TUESDAY, SEPTEMBER 15, 2026

9 House of Representatives,

10 Subcommittee on Health,

11 Committee on Energy and Commerce,

12 Washington, D.C.

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16 The subcommittee met, pursuant to call, at 10:30 a.m.

17 in Room 1334 of the Longworth House Office Building, Hon.

18 Morgan Griffith [chairman of the subcommittee] presiding.

19 Present: Representatives Griffith, Harshbarger,

20 Bilirakis, Carter of Georgia, Joyce, Balderson, Miller-Meeks,

21 Cammack, Bentz, Houchin, Rulli, and Guthrie (ex officio);

22 Ruiz, Dingell, Kelly, Barragan, Schrier, Veasey, Fletcher,

23 Carter of Louisiana, Landsman, and Pallone (ex officio).

24 Also Present: Clarke, McClellan, and Tonko.

25 Staff Present: Ansley Boylan, Director of Operations;

26 Jessica Donlon, General Counsel; Sydney Greene, Director of

27 Finance and Logistics; Jay Gulshen, Chief Counsel; Annabelle

28 Huffman, Policy Analyst; Megan Jackson, Staff Director;
29 Olivia Jensen, Staff Assistant; Brayden Lacefield, Special
30 Assistant; Madeline Martinez, Staff Assistant; Ryan Murphy,
31 Director of Member Services; Brice Ogle, Special Assistant;
32 Claire Richey, Clerk; Jake Riith, Staff
33 Assistant; Chris Sarley, Member Services/Stakeholder
34 Director; Emma Schultheis, Professional Staff Member; Timothy
35 Trimble, Staff Assistant; Matt VanHyfte, Communications
36 Director; Katie West, Press Secretary; Nick Wooldridge,
37 Professional Staff Member; Lydia Abma, Minority Policy
38 Analyst; Jacqueline Bolen, Minority Senior Counsel; Keegan
39 Cardman, Minority Legislative Clerk; Kayla Christopher,
40 Minority Intern; Tiffany Guarascio, Minority Staff Director;
41 Perry Hamilton, Minority Deputy Director, Member Services and
42 Outreach; Una Lee, Minority Chief Counsel, HE; Brendan Lopez,
43 Minority Press Assistant; Jack Malo, Minority Fellow, HE;
44 Neel Roy, Minority Fellow, HE; Laurel Uhomba, Minority
45 Fellow, HE; and Nick Wallace, Minority Professional Staff
46 Member.
47

48 *Mr. Griffith. The subcommittee will come to order.
49 The chair recognizes himself for a five-minute opening
50 statement.

51 First, I should probably say before we start the five
52 minutes, that we are in a different room today. So, if there
53 is a little confusion as we do things, please forgive us.

54 All right, today we will examine several bills that work
55 to address challenges in the Medicare physician fee schedule,
56 as well as bills that aim to enhance health care
57 cybersecurity. This hearing will further our efforts in
58 finding ways to improve the Medicare payment system and
59 provide greater stability for health care providers across
60 the country.

61 Under the leadership of Dr. Michael Burgess, this
62 committee and subcommittee worked diligently to modernize and
63 improve Medicare physician payment, especially through the
64 Medicare Access and Children's Health Care Insurance Program
65 Reauthorization Act, or MACRA. It is important that we
66 continue to build on those efforts because we still hear of
67 the challenges providers face due to payment uncertainty and
68 regulatory complexity, which can divert time and resources
69 away from patient care.

70 These pressures can be particularly difficult for
71 independent rural practices with limited resources, and
72 frequent changes to payment policies can make it even harder

73 to provide care. One of the bills before us today is the
74 Patients First Act, which would comprehensively modernize
75 physician payment for the first time since MACRA became the
76 law in 2015. The bill is led by Representative Joyce of
77 Pennsylvania and Representative Schrier of Washington. I
78 want to thank both members for their work on this policy,
79 which gives us an opportunity to address some of the
80 longstanding challenges within the Medicare physician payment
81 system.

82 The Provider Reimbursement Stability Act is another bill
83 that aims to update the underlying structure of the physician
84 fee schedule to improve predictability for physician
85 payments, and it is being led by Representative Murphy of
86 North Carolina and Representative Schneider of Illinois.

87 MACRA tried to move away from a traditional fee-for-
88 service payment structure, which requires recurring
89 legislative doc fixes to prevent scheduled payment cuts to
90 doctor reimbursements. While MACRA permanently repealed the
91 older sustainable growth rate formula that caused significant
92 payment challenges, Congress still has to consider short-term
93 legislative patches to stabilize fee-for-service payment
94 rates. By the end of this year, we in Congress will again
95 need to look at a potential doc fix, and these bills try to
96 get at some of those challenges.

97 Another bill before us is the Ensuring Community Access

98 to Pharmacist Services Act, or ECAPS, led by Representative
99 Smith of Nebraska and Representative Schneider of Illinois.
100 This legislation would expand Medicare coverage for certain
101 pharmacist services, such as pharmacists providing testing.
102 Community pharmacists are often among the most accessible
103 providers in rural areas, which makes this legislation
104 important for communities such as my district, where many
105 patients consider the pharmacy a critical point of care.

106 Additionally, the Alzheimer's Screening and Prevention
107 Act, or ASAP Act, is led by Representative Buchanan of
108 Florida and Representative Tonko of New York, and it would
109 create a pathway for Medicare to cover FDA-approved blood-
110 based biomarker screening tests for early detection of
111 Alzheimer's and other related dementias.

112 Further, I look forward to continuing the work on the
113 Rural Obstetrics Readiness Act which aims to help prepare
114 rural hospitals and practitioners for obstetric emergencies.
115 It is led by Representative Kelly of Illinois and
116 Representative Kim of California.

117 We often hear about the challenges women and families
118 face in accessing maternal health care, particularly in rural
119 areas such as my district. Many communities face shortages
120 of obstetric providers, limited access to local maternity
121 services, and growing maternity care deserts, and it is
122 important that we continue to look for ways to address the

123 maternal health care crisis that is facing our country.

124 Two other bills before us today are the Kidney Care
125 Access Protection Act and the Keeping Individuals with
126 Dialysis Needs Equipped Through Year-round Remote Monitoring
127 Act, which both aim to improve care access for individuals
128 affected by kidney disease.

129 Among several other Medicare payment reform bills we
130 will also discuss bills related to therapeutic shoes for
131 those with diabetes, as well as legislation to -- that
132 modernizes and expands access to cyber resources to help
133 combat growing cybersecurity threats.

134 I am looking forward to our conversation, and thank you
135 to the witnesses for being here today.

136 [The prepared statement of Mr. Griffith follows:]

137

138 *****COMMITTEE INSERT*****

139

140 *Mr. Griffith. I now recognize the acting ranking
141 member, Representative Fletcher of Texas, for a five-minute
142 opening statement.

143 *Mrs. Fletcher. Thank you so much, Chairman Griffith,
144 and I am glad to be with you here today because many of the
145 bills that we are discussing today are important pieces of
146 legislation for my constituents and for communities across
147 the country, and this hearing provides us the opportunity to
148 continue important conversations about reforming Medicare
149 payments for providers and to discuss policies aimed at
150 improving the security of Americans' health data: something
151 that is critically, critically important.

152 Many of the other bills we are discussing today are also
153 important steps toward expanding access to care for people
154 across the country. And while I hope that today we are able
155 to discuss some thoughtful recommendations and ideas, I once
156 again caution everyone that these are not normal times and we
157 cannot have a hearing on the legislation aimed at reforming
158 our health care system without discussing the ways that this
159 Administration and this Congress are actively harming
160 providers and patients with the policies that this Congress
161 has enacted over the last two years.

162 So I know how important it is to pass legislation that
163 will address the cuts to Medicare physician payments and
164 ensure that physicians are receiving adequate reimbursements

165 that will allow them to keep their doors open and to continue
166 treating Medicare patients. In fact, it is one of the top
167 issues I hear about from providers that I represent, and
168 many, many physicians live and work in my district.

169 But at the same time I am hearing about this issue, I
170 have also spent all of this Congress hearing from so many
171 providers about the devastating effects of the so-called One
172 Big, Beautiful Bill. And I can't get into all of it, but
173 between the cuts to Medicaid and the expiration of the
174 Affordable Care Act Enhanced Premium Tax Credits, it is
175 estimated that nearly 15 million people will lose access to
176 health care. And the loss of coverage estimates don't even
177 include the additional number of people who are forced to
178 shift their health care plans, who get health care plans that
179 are not as good because they can't afford the ones that they
180 had as the costs get shifted throughout the system.

181 And what we know is that that is leaving millions and
182 millions of Americans under-insured, uninsured, and unable to
183 access care. When more people are uninsured and under-
184 insured, it drives up costs. It drives up the cost for
185 uncompensated care, it drives up the -- that increases the
186 costs for not just the providers, but every single
187 participant in our health care system, especially patients.

188 Our health care system works as an ecosystem. If costs
189 increase in one part of the system, those costs are incurred

190 in other parts of the system. Providers are forced to make
191 cuts elsewhere in the health care system to make up for the
192 increasing uncompensated care costs. And we have already
193 seen providers across the country begin to lay off staff,
194 reduce health care services, and even close their doors
195 altogether. It is expected that these cuts to jobs and
196 health care services will become even more drastic once more
197 of the provisions in that so-called One Big, Beautiful Bill
198 take effect.

199 They haven't all taken effect yet, but we know that
200 since it was signed into law the Trump Administration has
201 issued a series of rules to implement the provisions of the
202 bill that go even further than the statutory requirements in
203 the bill, further reducing access to care and placing even
204 more strain on health care providers and our health care
205 infrastructure overall. And with providers forced to cut
206 services and staff, this means that it is not only those who
207 are on Medicaid or who received the Enhanced Premium Tax
208 Credits who will lose access to care or see their health care
209 costs increase. It will be more difficult for all Americans
210 to access the care that they need.

211 This will likely result in many Americans delaying or
212 foregoing care altogether. And when people delay or forgo
213 care, that is harmful for their health and for the health of
214 our communities. And physician after physician has told me

215 this. Public health expert after public health expert has
216 told us this. It is time for us to respond to it. For an
217 Administration that claims it wants to make America healthy
218 again, the actions prove the opposite, that it is doing
219 everything but that and not making us healthier, but making
220 it more difficult and more expensive to access health care.

221 So I welcome the discussion today on pieces of
222 legislation that will protect and expand access to care for
223 Americans all across the country, but we on this committee
224 also need to address the ways that policies that have been
225 recently enacted have cut off access to care and have driven
226 up health care costs for millions of Americans. And I hope
227 that the committee will take the opportunity to do that in
228 future hearings.

229 [The prepared statement of Mrs. Fletcher follows:]

230

231 *****COMMITTEE INSERT*****

232

233 *Mr. Griffith. The gentlelady yields back. I now
234 recognize the chairman of the full committee, the gentleman
235 from Kentucky, Mr. Guthrie.

236 *The Chair. Thank you. Thank you, Mr. Chairman. Thank
237 you, Chair Griffith, for holding this hearing. I will be
238 brief.

239 As the committee has already done extensive work
240 examining the provider landscape and subsequent payment
241 reform, earlier this year we heard from witnesses as part of
242 our affordability series, followed by a hearing this spring
243 focused on Medicare physician payment reforms. Today we will
244 build on that work by considering a range of legislative
245 proposals aimed at strengthening the ability of our nation's
246 providers to deliver enhanced care for Americans.

247 Additionally, we are considering two pieces of
248 legislation to address cybersecurity threats in the public
249 and private health sectors that pose serious risks to patient
250 safety and privacy.

251 H.R. 9908, the Rural Hospital Cybersecurity Enhancement
252 Act, led by my colleagues Representative Houchin and Schrier,
253 would support rural hospitals' critical cybersecurity
254 infrastructure by requiring HHS to establish a comprehensive
255 workforce development strategy that addresses the need for
256 cybersecurity professionals in rural hospitals. The bill
257 also requires HHS to publicly publish materials for rural

258 hospitals to train their staff.

259 Similarly, the Health Care Cybersecurity and Resiliency
260 Act of 2026 would expand resources for preventing and
261 responding to cybersecurity incidents across the health care
262 system, require health care providers and plans to include
263 the number of individuals affected when notifying them of a
264 breach.

265 I thank all of our witnesses for being here today, I
266 look forward to hearing from your testimony. I thank the
267 chairman.

268 [The prepared statement of The Chair follows:]

269

270 *****COMMITTEE INSERT*****

271

272 *The Chair. And I will yield back.

273 *Mr. Griffith. The gentleman yields back. I now
274 recognize the ranking member of the full committee,
275 Representative Pallone, for five minutes for an opening
276 statement and a point of personal privilege over and above
277 the five minutes.

278 Mr. Pallone.

279 *Mr. Pallone. Thank you. It is good to see you today.
280 I know you have been chairman of two committees since I saw
281 you last, Rules and here, today.

282 But this is our last Health Subcommittee hearing before
283 House Republicans send us back to our districts until after
284 the election. And it is important, as we discuss these
285 legislative proposals today, that we not forget the
286 Republicans' big, ugly bill cut American health care by more
287 than \$1 trillion, the largest cut in our nation's history.
288 And these massive cuts will result in 15 million people
289 losing their health insurance.

290 Insurance premiums spiked for 20 million people in the
291 beginning of the year because Republicans refused to extend
292 the ACA tax credits. And while Republicans are holding a
293 hearing to discuss the challenges that providers face in the
294 Medicare physician fee schedule, hospitals and clinics are
295 closing in record numbers across the nation because of
296 Republicans' health care cuts. Approximately 10,000 health

297 care workers have already been laid off, and another 300
298 hospitals, clinics, and home care providers are closing down
299 altogether or reducing services. So that is the health care
300 environment that we face today. It is a disaster, in my
301 opinion.

302 But let me get to the bills that we are considering
303 today. We will discuss a number of bills that would reform
304 and modernize the Medicare physician fee schedule. When
305 Congress passed the Medicare Access and Chip Reauthorization
306 Act, or MACRA, there was hope that it would stop that roller
307 coaster of payment cuts and create a system for reliable
308 Medicare payments to health care providers based on the
309 quality of care that patients received.

310 A fundamental portion of MACRA was the merit-based
311 incentive payment system. That system was intended to
312 provide better pay for healthcare providers who provide
313 better care. In reality, this system has appeared to create
314 additional administrative burdens for providers without
315 producing significant improvements in patient care, in my
316 opinion. I believe any reforms to the Medicare physician
317 payment system needs to ensure that Medicare remains viable
318 while ensuring that patients receive quality care and doctors
319 receive fair compensation.

320 Any changes in the payment system should also improve
321 how we evaluate the quality of care seniors receive without

322 imposing burdensome administrative requirements on
323 physicians. At the end of the day Congress must prioritize
324 access to high-quality care for all Medicare beneficiaries
325 when and where they need it, and we must ensure any changes
326 that we are considering today do not result in increases in
327 Medicare beneficiaries' premiums or out-of-pocket costs.

328 We will also consider legislation that would require
329 Medicare coverage of Alzheimer's disease early detection
330 screening tests. These tests have the potential to offer a
331 transformative approach to early Alzheimer's screening. Any
332 further changes to this bill must ensure it does not hinder
333 the Center for Medicare and Medicaid Services's ability to
334 collect data and real-world evidence in order to inform
335 coverage determinations, and must also treat all Medicare
336 beneficiaries equally.

337 We are also considering two health care cybersecurity
338 bills that are intended to enhance health care privacy and
339 better protect our health care infrastructure from cyber
340 attacks and intrusions, and I continue to believe that we
341 should address online holistically -- look at this,
342 "holistically" -- of which health care privacy is an
343 integral and essential aspect of these efforts. But I am
344 looking forward to the discussion today, and I believe we
345 must find bipartisan solutions on this issue.

346 I also believe that Medicare beneficiaries should have

347 access to routine services they need in the most accessible
348 locations, including their local pharmacies, and I believe
349 that H.R. 3164 can help us to do that.

350 Now, turning to public health, we will consider a bill
351 that would help prepare rural providers to handle obstetrics
352 emergencies, and another bill that would help develop a
353 comprehensive strategy to prevent, diagnose, treat, and cure
354 epilepsy, one of the most common neurological conditions that
355 we have here in the United States.

356 [The prepared statement of Mr. Pallone follows:]

357

358 *****COMMITTEE INSERT*****

359

360 *Mr. Pallone. So I thank Mr. -- Chairman -- let me just
361 add, if I could -- I know I am going over time here, but I
362 wanted to take a moment to thank Una Lee for her more than 11
363 years here at the Energy and Commerce Committee, most of
364 those years serving as chief counsel for the Health
365 Subcommittee.

366 She has played a critical role in every major health
367 care bill that has been signed into law during that time.
368 That includes the American Rescue Plan during the COVID
369 pandemic and the bipartisan No Surprises Act which ended the
370 practice of surprise medical bills for patients, and has also
371 led the health team during passage of the Inflation Reduction
372 Act, which finally empowered Medicare to negotiate lower
373 prescription drug prices for America's seniors. And this
374 legislation is saving seniors billions of dollars on the
375 drugs that have already been negotiated, and there will be
376 more negotiations this year and in the years to come,
377 building on those savings.

378 So Una has been a trusted advisor. She is going to be
379 missed here at the committee, very seriously missed. And I
380 wish her nothing but the best in her future endeavors. I
381 wish she wasn't leaving, but -- I usually say that about
382 anybody leaves who is good, but in her case it is even more
383 of -- that I wish she wasn't leaving. But I wish her best in
384 her future endeavors and congratulate her for her tremendous

385 work of making health care more affordable and accessible for
386 every American.

387 So all the best, Una. Thank you for everything.

388 [Applause.]

389 *Mr. Pallone. Thank you, Mr. Chairman. I yield back.

390 *Mr. Griffith. Thank you, and I would be remiss if I
391 didn't say that -- and I think most people who watch us know
392 that without the team behind us we couldn't get anything
393 done. It is very helpful to have their input, their
394 knowledge, and their advice. So thank you.

395 All right, we want -- I skipped a paragraph. We now
396 conclude with member opening statements. The chair would
397 like to remind members that, pursuant to the committee rules,
398 all members' opening statements will be made a part of the
399 record.

400 We want to thank our witnesses for taking their time to
401 be with us today and to testify before this subcommittee.
402 Although it is not the practice of this subcommittee to swear
403 in witnesses, I will remind our witnesses that knowingly and
404 willfully making materially false statements to the
405 legislative branch is against the law under title 18, section
406 1001 of the United States Code.

407 You will have an opportunity to give an opening
408 statement, followed by questions from members.

409 Our witnesses today are Mr. Greg Garcia, executive

410 director for cybersecurity, Healthcare and Public Health
411 Sector Coordinating Council, HSCC; Dr. Anthony Pudlo, PharmD,
412 MBA, MS, chief executive officer of the Tennessee Pharmacists
413 Association, TPA -- and are you keeping Mrs. Harshbarger in
414 line, I am just saying; yes, Dr. Murad Alam, MD, MSCI, MBA,
415 FAAD, president, American Academy of Dermatology Associates
416 (sic), AADA; Dr. Rebecca Andrews MS, MD, MACP, immediate past
417 chair, Board of Regents, American College of Physicians, ACP;
418 and Dr. Eilean Attwood, MD, MPH, immediate past chair of the
419 Committee on Health Economics and Coding, American College of
420 Obstetricians and Gynecologists, ACOG; and Ms. Gabi Conecker
421 -- thank you -- MPH, co-founder and executive director,
422 Decoding Developmental Epilepsies.

423 Per committee custom, each witness will have the
424 opportunity for a five-minute opening statement, followed by
425 a round of questions from the members.

426 The light on the timer in front of you will turn from
427 green to yellow when you have one minute left.

428 I now recognize Mr. Greg Garcia for his five minutes to
429 give an opening statement.

430 Mr. Garcia.

431

STATEMENT OF GREG GARCIA, EXECUTIVE DIRECTOR FOR
CYBERSECURITY, HEALTHCARE AND PUBLIC HEALTH SECTOR
COORDINATING COUNCIL (HSCC); ANTHONY PUDLO, PHARMD, MBA, MS,
CHIEF EXECUTIVE OFFICER, TENNESSEE PHARMACISTS ASSOCIATION
(TPA); MURAD ALAM, MD, MSCI, MBA, FAAD, PRESIDENT, AMERICAN
ACADEMY OF DERMATOLOGY ASSOCIATION (AADA); REBECCA ANDREWS,
MS, MD, MACP, IMMEDIATE PAST CHAIR, BOARD OF REGENTS
(2026-2027), AMERICAN COLLEGE OF PHYSICIANS (ACP); EILEAN
ATTWOOD, MD, MPH, IMMEDIATE PAST CHAIR OF THE COMMITTEE ON
HEALTH ECONOMICS AND CODING, AMERICAN COLLEGE OF
OBSTETRICIANS AND GYNECOLOGISTS (ACOG); AND GABI CONECKER,
MPH, CO-FOUNDER AND EXECUTIVE DIRECTOR, DECODING
DEVELOPMENTAL EPILEPSIES

STATEMENT OF GREG GARCIA

*Mr. Garcia. Thank you, Mr. Chairman and members of the
committee. Thank you for inviting me to testify. Today I
will discuss cyber threats to the health care system and
patient safety and what we can do about it.

The Health Sector Cybersecurity Working Group is an
industry-led advisory council of almost 500 health care
organizations and government agencies, and we work together
to identify and mitigate systemic threats and vulnerabilities
that affect the delivery and support of health care. At the

457 heart of this work is the guiding principle that cyber safety
458 is patient safety.

459 Twenty-five years ago last Friday the United States
460 suffered the worst attack on American soil in the nation's
461 history. It resulted in the deaths of more than 3,000 people
462 on that day and in its aftermath. While I watched archival
463 news coverage of that event last weekend, I pondered how many
464 souls, how many more souls, might have been lost had those
465 terrorists added to their arsenal with simultaneous cyber
466 attacks on the neighboring hospitals. This blended attack
467 could have disabled clinical IT systems and medical devices
468 and providers' ability to care for the many people burned and
469 injured on that day. You should harbor no doubts that this
470 is a very real scenario.

471 Five years after the September 11 attacks, 20 years ago
472 this coming Friday in fact, I was appointed as the nation's
473 first DHS Assistant Secretary for Cybersecurity. This new
474 role was created in part to counter the prospect of that kind
475 of devastating blended attack. In reminding me last week
476 about the linkage between those two September days, a
477 colleague made a trenchant observation. She told me, "You
478 know, since your appointment the same technology that has put
479 a cardiologist beside a patient's heart hundreds of miles
480 away has also handed a criminal on another continent a weapon
481 to hold for ransom: her life support.'" This is the

482 challenge before us in the health sector and before this
483 committee.

484 For our part, the many cybersecurity professionals in
485 our membership have since 2019 produced almost 40 healthcare
486 cybersecurity best practices by the sector, for the sector,
487 and some jointly published with HHS. I would commend to my
488 clinical colleagues here we also have produced a
489 cybersecurity for the clinician video training series: 40
490 minutes of your time well spent, and that is available free
491 on our website.

492 Implementation of these tools will measurably improve
493 the security and resiliency of the nation's health care
494 system if we can get them to the stakeholders who need them
495 with the government's help at scale. And this is especially
496 important for the nation's rural and resource-constrained
497 health providers. They are the most vulnerable to evolving
498 malicious cyber threats, and this calls for a concerted,
499 multi-pronged combination of government programs, assistance,
500 and funding coupled with market-based mutual support,
501 community defense, and a safe harbor when they take
502 appropriate steps to protect themselves but still get
503 attacked.

504 Today the committee has two cybersecurity bills pending
505 before you, and while the HSCC has not formally considered
506 these bills, I can say that they represent a welcome

507 indication of this committee's attention to this complex and
508 evolving challenge. Together these bills direct
509 cybersecurity coordination across HHS, CISA, and the health
510 care sector, and provide specific targeted assistance to the
511 nation's small, rural, and resource-constrained health
512 providers.

513 I can also say that where clarifications and refinements
514 are needed in certain provisions, we stand ready to work with
515 the committee to consider appropriate recommendations.

516 Some of our suggestions would include the need to, one,
517 direct HHS and CISA to formally involve the Council in
518 cybersecurity deliberations, threat information-sharing, and
519 incident response advisories to the community.

520 Two, clarify section 4 of the Cyber Resiliency Act to
521 require that the HHS designee for internal and external
522 cybersecurity coordination be at the Deputy Assistant
523 Secretary level or above, with the appropriate authority to
524 influence policy and programmatic decisions.

525 Three, ensure that grant funding is available to the
526 broadest community of resource-constrained health providers,
527 and allow use of those funds to replace legacy medical
528 devices that are too old to secure.

529 And finally, four, avoid congressionally-prescribed
530 technical solutions such as multi-factor authentication and
531 encryption. These might be correct today, but technology is

532 constantly evolving in ways that will change the meaning, the
533 implementation, and effectiveness of technical products and
534 methods. Such technical guidance, in our view, is better
535 left to evolving industry security frameworks that are widely
536 recognized and referenced in law and operations.

537 Mr. Chairman, that concludes my remarks and I will be
538 happy to answer any questions.

539 [The prepared statement of Mr. Garcia follows:]

540

541 *****COMMITTEE INSERT*****

542

543 *Mr. Griffith. I appreciate it. The gentleman yields
544 back. I now recognize Dr. Anthony Pudlo for his five-minute
545 opening statement.

546

547 STATEMENT OF ANTHONY PUDLO

548

549 *Dr. Pudlo. Thank you, Chairman Griffith, Ranking
550 Member Fletcher, Vice Chair Harshbarger, and members of the
551 subcommittee. Thank you for the opportunity to testify
552 today. I especially want to thank Vice Chair Harshbarger, a
553 fellow Tennessean and pharmacist, for her leadership in
554 expanding access to timely, affordable health care. My name
555 is Anthony Pudlo, and I serve as the chief executive officer
556 of the Tennessee Pharmacists Association.

557 Today I am here because too many seniors are still being
558 denied timely access to care that may be available just
559 minutes from their homes. You have a bill before you to
560 address this issue that has strong bipartisan support among
561 members of this committee, with 38 cosponsors among its
562 members, including 20 Republicans and 18 Democrats.

563 Now picture a senior who wakes up on a Saturday morning
564 struggling with respiratory conditions. Her physician's
565 office is closed. Obtaining a timely appointment may be
566 difficult whether she lives in a rural community or a busy
567 urban area, and waiting could allow a manageable illness to

568 become far more serious. But her trusted pharmacy is open,
569 her local pharmacist is nearby, trained, and authorized by
570 state law to provide the care she needs. Yet because she
571 relies on Medicare, coverage for those services may not be
572 available. That is the gap H.R. 3164, the Ensuring Community
573 Access to Pharmacist Services Act, or ECAPS, would help
574 close.

575 Throughout my career I have viewed health care from many
576 perspectives: as a practicing pharmacist caring directly for
577 patient care, as a leader developing innovative pharmacy
578 practice models, and as an advocate working with policy-
579 makers and other healthcare professionals. All those
580 experiences reinforced a simple truth: pharmacists are among
581 the most accessible healthcare professionals in a patient's
582 life. For many seniors the pharmacy is more than a place
583 just to pick up a prescription; it is often the most
584 accessible point of entry into the health care system.
585 Patients trust their pharmacists because of relationships
586 built over years and often decades of care.

587 Now consider the Medicare beneficiary in rural
588 Strawberry Plains, Tennessee who wakes up with those
589 respiratory symptoms but cannot reach a physician office who
590 might be miles away. Or consider the senior in an urban
591 neighborhood of Memphis, Tennessee who may live near medical
592 facilities but still cannot obtain a timely appointment or

593 easily travel across the city for care, even though that
594 trusted community pharmacist is nearby and available. Too
595 often these seniors are faced with a difficult choice: wait
596 and hope that they get better or seek care in a higher-cost
597 setting such as an emergency department.

598 In Tennessee pharmacists are authorized under state law
599 to order testing and provide treatment for common respiratory
600 illnesses. Tennessee, along with 27 other states, already
601 authorized their Medicaid and commercial health plans to
602 cover such services. Medicare beneficiaries, however, they
603 are often the only patients unable to access coverage for the
604 same pharmacist-provided services. ECAPS would address this
605 disparity by covering pharmacist-provided services under
606 Medicare Part B for common respiratory conditions under state
607 scope of practice and as part of the patient's health care
608 team.

609 America's pharmacists are ready. On behalf of the
610 seniors, families, and caregivers who should not have to wait
611 until a manageable illness becomes a medical emergency, I
612 respectfully urge this committee to swiftly advance the
613 Ensuring Community Access to Pharmacist Services Act, and let
614 us give seniors access to the care that is already close to
615 home, and help them remain where they most want to be:
616 healthy, independent, and with the people they love.

617 Thank you for your leadership and for the opportunity to

618 testify, and I welcome your questions.

619 [The prepared statement of Mr. Pudlo follows:]

620

621 *****COMMITTEE INSERT*****

622

623 *Mr. Griffith. Thank you very much. I now recognize
624 Dr. Murad Alam for his five minutes of opening statement.

625

626 STATEMENT OF MURAD ALAM

627

628 *Dr. Alam. Thank you, Chairmen Guthrie and Griffith,
629 Ranking Members Pallone and Fletcher, members of the
630 subcommittee. My name is Dr. Murad Alam, and I am president
631 of the American Academy of Dermatology which represents
632 18,000 physicians nationwide. I am also the vice chair and a
633 professor in the department of dermatology at Northwestern
634 University Feinberg School of Medicine in Chicago.

635 In my practice, which focuses on skin care, skin cancer
636 care, I treat patients who travel from far away, including
637 rural areas and adjoining states, because they cannot find
638 care closer to home. Many of these patients return again and
639 again because they depend upon me to catch cancerous spots.
640 Perhaps it is a new growth on their back that the patient
641 cannot see or a suspicious sore on their nose that the
642 patient isn't quite sure was there before.

643 Skin cancer is the most common cancer in the United
644 States, with most skin cancer patients 65 or older.
645 Dermatologists are expert at evaluating skin lesions,
646 distinguishing benign from malignant disease, and treating
647 skin cancer when it is localized and most treatable. Most of

648 this care is in private practices rather than in hospitals.
649 Prevention, early detection, and access to high-quality
650 dermatologic care is particularly important for Medicare
651 beneficiaries, given their elevated risk of skin cancer.

652 When detected early, 99 percent of skin cancers can be
653 cured, commonly with a single in-office procedure. When
654 detected later, skin cancers that have advanced or spread
655 typically require treatment with expensive and toxic
656 medications, and only 35 percent of patients survive. A
657 disheartening part of practicing medicine is discovering a
658 lesion that, had it been found earlier, could have been
659 treated more easily. We saw this repeatedly during the
660 pandemic. I told my staff, "I know you are scared, but we
661 have to see patients. We cannot let time pass without them
662 being checked.'" We stayed open and we prevented suffering
663 and likely saved lives.

664 Unfortunately, between Medicare physician payment cuts
665 and mounting administrative burdens, physicians are facing
666 death by 1,000 cuts, a slow erosion that is driving burnout
667 and threatening patient access to care. Every closed
668 practice, every delay in care, every unfilled position that
669 further hampers care delivery threatens the long-term utility
670 of Medicare. While I continue to encourage my medical
671 residents and fellows to start independent practices in
672 underserved areas, it is increasingly difficult to make that

673 case. Between payment cuts, consolidation, and
674 administrative burdens, they fear they cannot survive on
675 their own, even when the desire to serve these communities is
676 there.

677 Congress must act to reform Medicare physician payment
678 by establishing a positive annual inflation adjustment and
679 increasing the budget neutrality threshold. In addition to
680 the expiration of the 2.5 percent update Congress provided
681 only for 2026, CMS's proposed rule for the 2027 Medicare
682 physician fee schedule includes cuts of 11 percent for
683 dermatology's medically necessary services, cuts that
684 cumulatively rise to at least 16 percent when fully phased
685 in, thereby further destabilizing private, independent
686 practices. These proposed reductions directly threaten skin
687 cancer prevention and treatment. If these cuts become
688 reality, physicians would be forced to reduce staffing and
689 limit the number of Medicare beneficiaries they can serve.

690 We extend our gratitude to Representatives John Joyce,
691 Greg Murphy, and Kim Schrier for their leadership in
692 introducing H.R. 9693, the Patients First Act. While
693 physicians have long advocated for inflation updates tied to
694 the full Medicare Economic Index, the inflationary update
695 policy in the Patients First Act would be a vital building
696 block towards long-term, sustainable, and predictable annual
697 adjustments.

698 I thank you for holding this hearing and for your
699 commitment to ensuring patient access to life-changing
700 dermatologic care.

701 We must stop draconian cuts to Medicare physician
702 payment. The price of delaying critical legislation like the
703 Patients First Act is lives. The Academy looks forward to
704 working with the committee as it considers the challenges
705 facing physician private practices. Thank you.

706 [The prepared statement of Dr. Alam follows:]

707

708 *****COMMITTEE INSERT*****

709

710 *Mr. Griffith. I thank the gentleman for his testimony.
711 I now recognize Dr. Rebecca Andrews for her five-minute
712 opening statement.

713

714 STATEMENT OF REBECCA ANDREWS

715

716 *Dr. Andrews. Good morning, Chairman Griffith and
717 Ranking Member Fletcher, the distinguished members of the
718 subcommittee, and thank you for the opportunity to testify
719 today.

720 "Who will take care of me?" That was a question that I
721 never thought of 10 years ago, but now I worry almost daily
722 when I imagine my future health. I am Dr. Rebecca Andrews,
723 an internal medicine physician, primary care, and the
724 immediate past chair of the Board of Regents for the American
725 College of Physicians. We represent more than 163,000
726 physicians, nearly half of the nation's primary care
727 physicians, along with those in hospital medicine and the
728 internal medicine sub-specialties.

729 Primary care is the foundation of every high-functioning
730 health system. A primary care physician is your health guide
731 over the course of your life, and the longitudinal
732 relationships that we build produce the trust for better
733 outcomes. Yet somehow the U.S. health outcomes still trail
734 other nations.

735 My testimony today is a tale of numbers. One-third of
736 our country, one hundred million people, do not have a
737 primary care physician. In my home state it takes a year to
738 get a new primary care physician. Of my 60 graduating
739 residents each year, very few choose primary care. This year
740 it was six; that was a good year. And while the average
741 medical student debt when they graduate is \$223,000, Medicare
742 payments have declined by 33 percent since 2001 when you
743 account for inflation. This has hit primary care the hardest
744 since we lack the procedural revenue that cushions other
745 specialties from the same cuts.

746 Medical students and residents must weigh their school
747 debt against their significantly lower earning potential in
748 primary care compared to other -- many other sub-specialties.
749 In other words, they simply cannot afford to go into primary
750 care.

751 Two years into practice I personally saw the tangible
752 evidence of the power of primary care. A 29-year-old woman
753 called me concerned about a breast lump, so I made her
754 patient number 26 that day, and I have now cared for her for
755 20 years through her cancer treatment, its recurrence, and
756 her second remission. It took me 10 years to convince her to
757 treat her depression, but that allowed her to go back to
758 work. For the past five years I have treated her diabetes
759 and just two weeks ago, with the help of my resident, after

760 years of discussion I finally convinced her to take a
761 medicine that would protect her against heart disease. This
762 is primary care, the comprehensive care that is under-valued
763 and built over years that produces the health outcomes we all
764 want.

765 Adding 10 primary care physicians to every 100,000
766 patients adds an average of 2 years of life expectancy. And
767 for all of you, adding 10 primary care physicians means that
768 your constituents will double their life expectancy by adding
769 them compared to any other type of physician, and yet we are
770 losing this practice area.

771 Still, I am buoyed by hope. The Patients First Act of
772 2026 is part of that hope, and I thank Drs. Joyce, Murphy,
773 and Schrier for leading the effort. Our written testimony
774 has more detail, but I want to highlight the potential.

775 A permanent inflationary update would ensure physician
776 payment never again goes three decades without an increase.
777 A five-year hybrid payment pilot would provide independent
778 primary care practices in addition to fee-for-service, a per-
779 member fee, recognizing that primary care happens on the
780 phone, through care coordination, and certainly beyond the
781 office visit. I use a similar model in my practice, and we
782 are able to have integrated social work, behavioral health,
783 and a pharmacy team. But this must not be offset by broad
784 cuts or cost sharing by patients.

785 So who will care for me in the future? To get more
786 medical students and residents into primary care, invest in
787 primary care through a mechanism not beholden to budget
788 neutrality; support coding policies that appropriately value
789 and recognize the time to provide longitudinal, comprehensive
790 care; use quality measures that are evidence-based, such as
791 the Quality Reform Task Force and the Patient First Act; and
792 build safeguards against physicians so they are not penalized
793 for their patient complexity and social risks.

794 Friday my resident asked me about the future of
795 medicine. He wants to go into primary care. The future
796 doctors are watching what you decide. But with input from
797 physicians and professional medical organizations, you have
798 the power to build a system that puts the physician in front
799 of the patient rather than behind mountains of paperwork.

800 Thank you for the opportunity to testify. I look
801 forward to your questions.

802 [The prepared statement of Dr. Andrews follows:]

803

804 *****COMMITTEE INSERT*****

805

806 *Mr. Griffith. Thank you very much. I now recognize
807 Dr. Eilean Attwood for her five-minute opening statement.

808

809 STATEMENT OF EILEAN ATTWOOD

810

811 *Dr. Attwood. Chairman Griffith, Ranking Member
812 Fletcher, and distinguished members of the subcommittee,
813 thank you for inviting me to speak with you today on behalf
814 of the American College of Obstetricians and Gynecologists.
815 My name is Dr. Eilean Attwood. I am a practicing OB/GYN in
816 Providence, Rhode Island, where I also serve as the co-
817 medical director of the emergency department at my primary
818 hospital, as well as hold privileges and work clinically at
819 two other low obstetric volume hospitals in the state. I am
820 also the immediate past chair of ACOG's Committee on Health
821 Economics and Coding.

822 ACOG, with more than 60,000 members, is the leading
823 physician organization dedicated to advancing women's health.
824 Our mission is to support our members to improve the lives of
825 our patients, their families, and communities. Key to
826 realizing that mission is ensuring sustainability of
827 physician practice and patient access to affordable, high-
828 quality, and safe health care.

829 One in three U.S. counties have no obstetric clinicians
830 or birthing facilities. More than 2.4 million women of

831 reproductive age live in these communities, and nearly 150
832 rural hospitals have stopped or plan to stop providing
833 obstetric services between 2020 and the end of this year.
834 This rapid increase in closure has reached crisis levels.

835 In rural areas, loss of hospital-based obstetric
836 services is associated with higher rates of out-of-hospital
837 and pre-term birth as well as lower rates of prenatal care,
838 with the maternal mortality rate in the United States
839 remaining unacceptably high, with notable disparities by both
840 race and rurality. This is why ACOG is proud to support H.R.
841 1254, the Rural Obstetrics Readiness Act. This bill would
842 create an obstetric readiness training program for rural
843 facilities without a dedicated labor and delivery unit,
844 provide new federal grants for those facilities to purchase
845 the necessary equipment, and create a pilot program to
846 support a warm line connecting OB/GYNs with clinicians in
847 rural facilities in need of urgent teleconsultation.

848 And this work is not just theoretical. We have done it
849 informally in Rhode Island and with significant positive
850 effect. Whether working in the emergency department or as
851 serving as the hospital's perinatal safety officer, I am
852 frequently on the receiving end of obstetric emergency
853 transfers, including those from facilities without a
854 dedicated labor and delivery unit. For example, I recently
855 took a call from a regional hospital that had a patient in

856 her second trimester present to their emergency department
857 with dangerously high blood pressure. Through our phone
858 consultation I was able to recommend the appropriate
859 medications to minimize her risk of stroke or seizure and
860 help determine if they could safely transport the patient to
861 our facility nearly an hour away, where we had the necessary
862 resources for this patient and her baby.

863 Additionally, we have grown our emergency department
864 training programs with other specialties, including emergency
865 and family medicine. We work alongside non-OB/GYN residents
866 and faculty to become more comfortable with obstetric
867 emergencies that may present to their local and rural
868 hospitals to become more agile and safely managing these
869 patients locally and best practices when transferring to a
870 higher level of care. With this in mind, we urge Congress to
871 pass the Rural Obstetrics Readiness Act this year.

872 I also want to express my support for efforts to fix the
873 flawed Medicare physician payment system. More than 80
874 percent of OB/GYNs accept Medicare, affirming the role we
875 play in caring for patients across the lifespan. Medicare
876 patient payment policies reach beyond the Medicare program,
877 with Medicaid, Tricare, and private insurers often following
878 Medicare's lead on physician payment rates.

879 The current system is not sustainable, and has
880 contributed to the consolidation of physician practice. As

881 you just heard, adjusted for inflation, Medicare physician
882 payment has declined nearly 33 percent over the last 25
883 years. The lack of inflationary update, the outdated budget
884 neutrality threshold, and the recent misguided efficiency
885 adjustment policy threatens not only the future of private
886 practice, but access to care writ large. We need a payment
887 system that recognizes the value and complexity of surgical
888 care as well as primary care, and adjust for inflation to
889 ensure that payment reflects the cost of providing that care,
890 that updates the budget neutrality cap, and that allows for
891 adjustments based on actual utilization.

892 We are urging Congress to pass both the Provider
893 Reimbursement Sustainability Act and the Patients First Act.
894 Together these bills will add much-needed stability to the
895 Medicare program and preserve the low volume threshold
896 necessary to enable OB/GYNs like me to remain in the program
897 while maintaining the shared priority of advancing access to
898 high-quality care.

899 We are nearing the end of this Congress, but there is
900 still time to pass these important bills to improve access to
901 high-quality care for patients, to support the long-term
902 sustainability of physician practice, and to elevate
903 obstetric readiness of rural hospitals across our nation.

904 Thank you for the opportunity to join you today, and I
905 welcome your questions.

906 [The prepared statement of Dr. Attwood follows:]

907

908 *****COMMITTEE INSERT*****

909

910 *Mr. Griffith. Thank you very much. I now recognize
911 Ms. Gabi Conecker for her five-minute opening statement.

912

913 STATEMENT OF GABI CONECKER

914

915 *Ms. Conecker. Thank you so much, Chairman Guthrie and
916 Ranking Member Fletcher and members of the subcommittee. My
917 name is Gabi Conecker, and I am the co-founder and executive
918 director of the epilepsy -- excuse me, Decoding Developmental
919 Epilepsies, and serve as a founding member of the Epilepsies
920 Action Network. But most importantly, I am Elliott's mother,
921 a child with a rare and catastrophic epilepsy, who joins me
922 today along with his sister, Vega, and my mother, JayEtta.
923 Epilepsy is always a family matter.

924 I am here today to ask you to pass the National Plan for
925 Epilepsy Act, H.R. 1189, which has generated significant
926 bipartisan support with 97 Representatives and 28 Senators
927 who have cosponsored the National Plan for Epilepsy Act. And
928 the Senate recently unanimously passed a modified version.

929 Nearly 3.4 million Americans live with epilepsy, and
930 roughly half a million of those are children. We have made
931 extraordinary scientific progress, but our system has not
932 kept pace. We need a national plan to translate that
933 progress into better care and outcomes for those living with
934 epilepsy.

935 My son, Elliott, began having seizures within days of
936 being born. They were dismissed for months and we were
937 delayed in accessing a neurologist. What followed was a
938 year-and-a-half diagnostic odyssey with more than a dozen
939 doctors, spinal taps, skin biopsies, MRIs, EEGs, hundreds and
940 hundreds of seizures, and many, many hospitalizations. In
941 2014 genetic testing revealed that my son has an SCN8A-
942 related disorder, a rare genetic condition that wreaks havoc
943 on every system in his body. I speak on his behalf and for
944 the countless others who cannot.

945 Elliott is 13, and he is my pride and my joy, but he
946 suffers immensely. Elliott cannot hold up his head
947 independently, grasp a toy, eat by mouth, tell me what he is
948 -- why he is hurting or what he likes. Every day I live in
949 fear that that day could be our last. And despite everything
950 we know now, after about a decade since the discovery of the
951 disorder, he has tried and failed nearly every anti-seizure
952 medication and -- he has failed nearly every seizure
953 medication that he has tried, and his treatment is still
954 largely trial and error.

955 Elliott's story is one of a catastrophic rare epilepsy
956 disorder, but there are so many others who live with profound
957 effects of epilepsy, the veterans who have suffered TBIs,
958 elder onset epilepsy, those with epilepsy that cannot get
959 pregnant or live in deep depression. For far too many

960 children I have seen pass away from drowning, respiratory
961 distress, multi-system organ failure -- in fact, one of every
962 1,000 people who live with epilepsy will pass away quietly in
963 the night from SUDEP, Sudden Unexpected Death in Epilepsy.

964 The terrible reality is that 1 in 26 people will develop
965 epilepsy in their lifetime. That equates to roughly one in
966 -- one child in every classroom. Families across the country
967 are navigating delayed diagnoses, disconnected care,
968 inadequate data, and treatments that far too often remain
969 guesswork.

970 As you all likely know, more than a dozen Federal
971 agencies are currently working in epilepsy: NIH, CMS, CDC,
972 FDA, Department of Education, Veterans Affairs. We have made
973 incredible, incredible progress in epilepsy research, and
974 there is incredible work happening in this country. Yet too
975 little of that knowledge is really translating into quickly
976 available treatments and outcomes for patients. At least
977 one-third of adults who live with epilepsy do not gain
978 seizure control, about a quarter of children. And for --
979 with a disorder like SCN8A that my son has, more than 60
980 percent of those children never gain seizure control.

981 We do not systematically track enough patients, their
982 care, and outcomes to meaningfully learn from each person.
983 As we have heard repeatedly today, clinicians are under
984 strain. They are managing complex, lifelong conditions amid

985 workforce shortages, administrative burdens, and limited
986 tools to predict what treatments will work and when. And as
987 we know, precision medicines are on the horizon, but
988 uncoordinated systems and -- are delaying the promise of
989 these lifesaving opportunities.

990 This fragmentation also has consequences for
991 affordability. Uncontrolled epilepsy drives significant
992 health care costs, and it is estimated that the total health
993 care burden for those living with epilepsy is at least \$54
994 billion. Better coordination can help us get patients to the
995 right diagnosis and treatments sooner, improving outcomes,
996 reducing avoidable costs, and giving health care providers
997 better information and tools to care for their patients.
998 Families like mine should not have to build the
999 infrastructure ourselves to find patients, collect data,
1000 develop guidelines, and push science toward treatments.

1001 The good news is that the epilepsy community has come
1002 together. One hundred and fifty organizations have endorsed
1003 the legislation, and we have already come together to develop
1004 consensus priorities for what could be included in a national
1005 plan for epilepsy. And when it is passed we stand by, ready
1006 to support Congress and the Secretary to advance this
1007 lifesaving work.

1008 In the world of epilepsy -- I am almost done, I promise
1009 -- there is a saying which is that time is brain. The longer

1010 we wait, the more damage that is done. It may already be too
1011 late for my son, but we have the chance with the National
1012 Plan for Epilepsy Act to take a historic step toward ending
1013 decades of fragmentation and ensuring that scientific
1014 progress more rapidly reaches the people who are -- who
1015 desperately need it.

1016 We need Congress to act now. And on behalf of Elliott,
1017 my family, and the millions of Americans and their families
1018 who live with epilepsy on a daily basis, I respectfully ask
1019 you to pass H.R. 1189 this year to give families like mine a
1020 future defined not by fear --

1021 *Mr. Griffith. Thank you.

1022 *Ms. Conecker. -- and lost potential, but by progress
1023 and possibility. Thank you.

1024 [The prepared statement of Ms. Conecker follows:]

1025

1026 *****COMMITTEE INSERT*****

1027

1028 *Mr. Griffith. Thank you for your testimony today. We
1029 will now begin questioning. I would ask that members not
1030 begin a new question to our witnesses as their five minutes
1031 is about to expire, and would encourage members to submit
1032 written questions for the record. I now recognize myself for
1033 five minutes of questioning.

1034 First with -- I would ask for unanimous consent to
1035 present for the record a letter from Congresswoman Jen
1036 Kiggans, a nurse practitioner who writes in support of H.R.
1037 1616, the Promoting Access to Diabetic Shoes Act.

1038 Without objection, so ordered.

1039 [The information follows:]

1040

1041 *****COMMITTEE INSERT*****

1042

1043 *Mr. Griffith. All right, Dr. Attwood, in my district,
1044 we have a limited number of OB/GYN specialists, and many are
1045 considered -- many areas are considered maternal health care
1046 deserts. Outside of payment stability, what are some other
1047 ways we can look to build the maternal health workforce
1048 pipeline, especially in rural communities where a lot of
1049 times it is not that the hospital is not willing, they just
1050 don't have providers?

1051 *Dr. Attwood. Absolutely. Thank you for that question.

1052 I think this is actually one of the unique opportunities
1053 that I have in my current workplace, where we work very
1054 closely with various trainees and other specialties and other
1055 clinicians. We work with family medicine residents,
1056 emergency medicine residents, women's health nurse
1057 practitioners, certified nurse midwives, multiple people who
1058 work out in the community and are able to take the training
1059 that we do in our emergency department for obstetric
1060 emergencies and be able to take that back locally.

1061 I was actually just working with a resident this past
1062 Sunday on call who looks forward to returning to where she
1063 grew up in Wyoming, or potentially in West Virginia --
1064 actually, we had this conversation -- to be able to take the
1065 training that she has gotten out of our emergency department
1066 specifically for obstetric emergency care, and take that
1067 back. She was so thankful that we have developed this

1068 program, and that is really what we are looking to be able to
1069 do on a national level formally through the Rural Obstetrics
1070 Readiness Act.

1071 *Mr. Griffith. Thank you very much.

1072 Dr. Andrews, from a provider perspective, how would a
1073 bill like the Alzheimer's Screening and Prevention Act change
1074 care for Medicare beneficiaries?

1075 Do you think that the bill would save costs for both
1076 patient and health care systems as a whole if individuals had
1077 access to these screenings with proper safeguards?

1078 *Dr. Andrews. Thank you for that question.

1079 I think of Alzheimer's like any chronic condition. The
1080 sooner we can diagnose it, the more we can treat it upfront
1081 and prevent some downstream adverse effects of that
1082 condition.

1083 In particular for something like Alzheimer's, it
1084 provides time for the family to plan. I have a family.
1085 There are three daughters and one wonderful mother who is my
1086 patient. They managed to keep her at home for her entire
1087 diagnosis because we did cognitive screening -- and it was
1088 prior to having ways to diagnose it, but we did cognitive
1089 screening. We knew what was coming. We got an aide in the
1090 house, we safeguarded her, and they did an amazing job as a
1091 family taking care of her. But those are the types of
1092 changes that early diagnosis can help with.

1093 Additionally, as a patient, her being able to figure out
1094 her financial will and other conditions helped pay for those
1095 so that it didn't burden the system with costly, unexpected
1096 admissions and other, you know, downstream effects.

1097 So I think it would be great to diagnose all conditions
1098 as early as possible.

1099 *Mr. Griffith. Thank you.

1100 Dr. Pudlo, in Virginia we have a statewide protocol that
1101 allows pharmacists to test and treat certain illnesses. From
1102 your experience in Tennessee, what impact have you seen these
1103 services have on senior patient health outcomes, particularly
1104 in rural areas like the ones that both Representative
1105 Harshbarger and I represent?

1106 *Dr. Pudlo. Yes, thank you for the question, Chairman.
1107 You know, I think it is a really great question.

1108 You know what H.R. 3164 is really focused about is that
1109 access, and I think amongst the states like Tennessee, like
1110 Virginia that already have that authority, it continues to
1111 provide not just the access to care like we have talked
1112 about, but I think it continues to show that we are triaging
1113 and helping getting patients into the health care system when
1114 there is limited access to care in a rural area, in both you
1115 all's cases.

1116 But ultimately, I do think that that access alone, it is
1117 not necessarily reducing disparities by any means. We

1118 continue to try to build that trust, and that is what I think
1119 statewide protocols and other authorities that are granted at
1120 the state level do.

1121 *Mr. Griffith. Thank you.

1122 Dr. Andrews, back to you. We heard a little bit on this
1123 in the openers, but the way the physicians are reimbursed by
1124 CMS is complex and confusing, and it requires budget
1125 neutrality. Can you briefly explain how this works in
1126 reality?

1127 And mainly -- I know you touched on it in your opening,
1128 but dumb it down for me and folks back home.

1129 *Dr. Andrews. I think it is actually pretty simple.
1130 You can't run a business, even if that business is a social
1131 need, if you have no idea how you are going to get paid 3
1132 months, 12 months later. And the instability makes it very
1133 difficult to plan, to recruit for the staffing and
1134 interdisciplinary team you need.

1135 In particular, if our country wants to move to making
1136 real change for health outcomes, we have to be able to
1137 innovate, and to innovate you have to be creative, and it
1138 takes time to make sure it is working. And with unstable
1139 reimbursement, it is just not possible. Thank you.

1140 *Mr. Griffith. Thank you. My time is up so I will
1141 yield back and now recognize Mrs. Fletcher for her five
1142 minutes of questioning.

1143 *Mrs. Fletcher. Well, thank you, Mr. Chairman, and
1144 thank you to our witnesses for your time and your testimony
1145 here today.

1146 Picking up where Chairman Griffith left off, I represent
1147 a lot of physicians in my district in Houston who have for
1148 years faced declining Medicare payment reimbursement because
1149 the reimbursement rates haven't kept pace with inflation or
1150 rising practice costs. And since 2001 Medicare physician
1151 payment has fallen about 33 percent when adjusted for
1152 inflation. The decreasing reimbursement rate is
1153 unsustainable, and it really threatens access for all
1154 patients to get access to care. So that has been an
1155 important focus for me in Congress.

1156 And I -- while I am glad that Congress has stepped in to
1157 provide some temporary and short-term solutions in the past,
1158 it is really critical that Congress focuses on providing a
1159 long-term reform for Medicare physician payments. And so I
1160 am grateful to my colleague, Representative Schrier, for
1161 introducing the Patient First Act to provide this long-term
1162 reform to Medicare physician payments. And I was glad to
1163 cosponsor this important legislation, and I hope that we will
1164 consider it in a markup this Congress.

1165 One of the other bills that we are talking about in this
1166 hearing that I want to highlight is the Rural Obstetrics
1167 Readiness Act. We have heard it before in this committee,

1168 but it really bears repeating that the United States of
1169 America has the highest maternal mortality rate of all
1170 developed countries. And it is important that we work to
1171 address the disparities in maternal health outcomes.

1172 And things are getting worse. Just last week, for
1173 example, a new report showed that the number of women who
1174 have died from ectopic pregnancies has nearly doubled in the
1175 last five years. So this bill is an important step in this
1176 work. But as I mentioned earlier, the provisions in the so-
1177 called One Big, Beautiful Bill Act decreased Medicaid
1178 reimbursement rates for hospitals, and that is also having a
1179 huge impact on access to obstetric care.

1180 And without getting into the details, I think everyone
1181 understands that it has created a financial strain on
1182 hospitals, and that when hospitals have constraints and they
1183 are looking for departments and areas that they can cut
1184 funding, the maternity ward is often the first and easiest
1185 option for hospitals that need to cut costs, and that is
1186 especially true in rural and underserved hospitals. It is
1187 just the fact that, even before this bill last year,
1188 hospitals were already struggling to keep their maternity
1189 wards open.

1190 From 2010 to 2024 more than 700 hospitals closed their
1191 maternity wards. And since the passage of the bill last
1192 year, more than 50 maternity wards have closed or announced

1193 plans to close. Experts are warning they are expecting even
1194 more of those, and so it is an issue that is particularly
1195 concerning to me.

1196 In Texas almost half of the 254 counties currently lack
1197 any access to maternity care. Texas already has the highest
1198 uninsured rate in the country, and it is expected to
1199 increase. And 50 percent of the births in Texas are covered
1200 by Medicaid, 50 percent. And right now the Trump
1201 Administration is currently withholding about \$9.8 billion
1202 for Texas's fiscal year 2027 Medicaid supplemental payments.
1203 Texas hospitals are losing \$27 million a day in Medicaid
1204 funding.

1205 So between all of these factors, I am concerned that
1206 more hospitals across Texas and across the country will close
1207 their maternity wards. So Dr. Attwood, with the time I have
1208 left, I just want to ask you how maternity wards closing in
1209 hospitals will impact patient access to care and, at the same
1210 time, your views on what those closures will mean for health
1211 outcomes for expectant mothers and the maternal mortality
1212 crisis that we are experiencing.

1213 *Dr. Attwood. Thank you very much, and, you know, as
1214 you noted, hospitals are closing at an alarming rate, and
1215 OB/GYN, or labor and delivery units in particular, are
1216 closing even faster than that. And the more we see labor and
1217 delivery units close, the harder it is to access that really

1218 important, high-quality, safe labor and delivery or
1219 obstetrics care, which means our patients are driving
1220 further, driving through potentially difficult conditions,
1221 needing to get a place.

1222 And just as we heard from our colleague, time is brain.
1223 Time is really important for our patients. We need them to
1224 be able to see their OB/GYN to get their safe care as quickly
1225 as possible. And so we do worry the more that these labor
1226 and delivery units close, the harder that care is to access.
1227 But that is also why the Rural Obstetrics Readiness Act is so
1228 important, to also be able to mitigate some of those changes
1229 so that we have the tools and supplies for our colleagues in
1230 those rural hospitals to be able to diagnose, evaluate,
1231 treat, and safely transfer those patients in the process of
1232 getting them to where they can see an OB/GYN like me.

1233 *Mrs. Fletcher. Well, thank you. I am at the end of my
1234 time, so I have additional questions for you that I will
1235 submit for the record.

1236 [The information follows:]

1237

1238 *****COMMITTEE INSERT*****

1239

1240 *Mrs. Fletcher. And with that I will yield back.

1241 *Mr. Griffith. Thank you very much. I now recognize
1242 the gentlelady, vice chair of the subcommittee from
1243 Tennessee, Mrs. Harshbarger.

1244 *Mrs. Harshbarger. Thank you, Mr. Chairman, and thank
1245 you to the witnesses for being here today. And I am happy to
1246 see my fellow Tennessean here, Anthony.

1247 And thank you for being here. We worked together for a
1248 lot of different legislation, and I appreciate your hard
1249 work.

1250 You know, today's hearing covers several important
1251 bills, including one of my bills. It is H.R. 5737. It is a
1252 Radiology Outpatient Ordering Transition Act. And I won't
1253 say that but only once. It is called the ROOT Act, and it is
1254 expected to save approximately 2 billion in reduced Medicare
1255 spending and produce 1.5 billion in savings for Medicare
1256 beneficiary over 10 years.

1257 Since 2023 the AUC program has been indefinitely paused
1258 because it became clear its requirements were not working as
1259 intended, and the ROOT Act will make the necessary fixes to
1260 address these problems so providers will have the clinical
1261 support tools at the point of care, strengthening the
1262 appropriate imaging utilization, and provide meaningful
1263 program evaluation for future improvements.

1264 Mr. Chairman, I would like to ask unanimous consent to

1265 enter the statement of the American College of Radiology in
1266 today's hearing record.

1267 *Mr. Griffith. Without objection --

1268 *Mrs. Harshbarger. Thank you, sir.

1269 *Mr. Griffith. -- so ordered.

1270 [The information follows:]

1271

1272 *****COMMITTEE INSERT*****

1273

1274 *Mrs. Harshbarger. Now -- okay, now I am going to focus
1275 on H.R. 3164. That is the ECAPS bill, the Ensuring Community
1276 Access to Pharmacists Act. And we will start with Mr. Pudlo.

1277 Tennessee has taken significant steps to expand the role
1278 of pharmacists in patient care. And, you know, I live in a
1279 rural district, our chairman lives in a rural district. It
1280 is just if -- when you have distressed and at-risk counties,
1281 it is hard to access care sometimes.

1282 So one point we don't discuss often enough is cost. So
1283 how can pharmacists providing care reduce costs and to help
1284 reduce the avoidable health care spending for both Medicare
1285 and taxpayers when you do the testing, treatment, or other
1286 clinical services closer to home?

1287 *Dr. Pudlo. Thank you for the question, Congresswoman,
1288 and I think, to continue to emphasize the points that not
1289 just in my verbal comments but written, is that we continue
1290 to see pharmacists -- by providing such services for testing
1291 and treating for respiratory illnesses, we are really helping
1292 that patient, preventing them from having to go to a higher-
1293 cost location.

1294 And I think even in my days as a practicing pharmacist,
1295 I saw the same thing. We were able to help navigate the
1296 complexities of our health care system and help that patient
1297 figure out where is the best source for them to get access to
1298 treatment.

1299 *Mrs. Harshbarger. Actually, that is true. You know, I
1300 have been doing this for 40 years. And as a pharmacist, they
1301 come in and we triage them, we send them to where they need
1302 to go, whether it is a physician or other outpatient
1303 facility. So let me turn my questioning to Dr. Andrews.

1304 You mentioned that only 6 of approximately 60 internal
1305 medicine residents in your program chose primary care. Do
1306 you believe Medicare's payment system is contributing to that
1307 workforce problem, and could the Patients First Act help with
1308 that?

1309 *Dr. Andrews. When I have a third-year resident asking
1310 me what I think about the 2027 Medicare proposed fee rule,
1311 yes, I think that the reimbursement plays a significant role.
1312 Just listening to the amount of debt they have and trying to
1313 pay for that.

1314 I think stabilization, you know, catching up on the 30
1315 years of inflation and then stabilization of payments,
1316 including, you know, the Patients First Act is going to
1317 stabilize APM payments for another three years. People who
1318 are in the midst of trying to provide higher-quality care can
1319 then get reimbursed and rely on that. I think all of that is
1320 really important to quite savvy medical residents who are
1321 thinking about how to survive and open their own practice.

1322 *Mrs. Harshbarger. Yes, because that is an anomaly to
1323 have your own practice, isn't it?

1324 *Dr. Andrews. It is now.

1325 *Mrs. Harshbarger. It is an anomaly. And I see a lot
1326 of docs now going out of their practice to do cash-based
1327 practices because of some of these things. Now I will go
1328 back to Mr. Pudlo.

1329 Based on your experience working with pharmacists across
1330 Tennessee, what would it mean to seniors if Congress passed
1331 H.R. 3164 and allowed Medicare to better align with the
1332 services that we can offer at the pharmacy counter?

1333 *Dr. Pudlo. Thank you for the question. I would say it
1334 means the world to pharmacists.

1335 There are so many pharmacists right now that are already
1336 providing such services, and they are seeing compensation
1337 whether it is for a commercial health plan or our TennCare
1338 program. But the majority of patients that come to a
1339 pharmacy are Medicare beneficiaries, and so it is really
1340 difficult for a pharmacy to completely transition their work
1341 flow and their practice model to do that. So to me it is --
1342 it would be a very big benefit.

1343 *Mrs. Harshbarger. It will be a big benefit. Okay.
1344 With that I yield back, Mr. Chairman.

1345 *Mr. Griffith. The gentlelady yields back. I now
1346 recognize Dr. Ruiz for his five minutes of questioning.

1347 *Mr. Ruiz. Yes, thank you so much. Let me just get my
1348 notes here.

1349 Today's hearing provides an important opportunity to
1350 improve access to care for our seniors and ensure that
1351 Medicare providers can deliver the care their patients
1352 deserve and depend on. For seniors on fixed incomes, where
1353 they receive services is not just a matter of convenience,
1354 but it directly affects their ability to afford and access
1355 health care.

1356 Millions of Medicare beneficiaries, especially those
1357 with serious chronic conditions, rely on office-based
1358 settings and ambulatory surgical centers for timely,
1359 affordable treatment. But reimbursement differences between
1360 these care settings, particularly for services requiring
1361 high-cost medical supplies, can push certain procedures out
1362 of the most convenient and affordable options for seniors.

1363 In my district the Imperial Valley has some of the
1364 fewest hospitals and surgical centers per capita in the
1365 country, meaning seniors often drive an hour or more for
1366 care. When reimbursements makes the procedure uneconomical
1367 for local providers, patients face added travel, missed work
1368 days, and delayed treatment with real consequences for their
1369 health. That is why I introduced the Promoting Fairness for
1370 Medicare Providers Act alongside my colleague, Representative
1371 Bilirakis.

1372 So this bill would correct this by aligning Medicare
1373 payment rates across care settings for procedures with high

1374 supply costs. Modernizing reimbursements and restoring
1375 payment parity would let seniors keep care with their trusted
1376 providers without disrupting their treatment.

1377 Dr. Andrews, beyond this legislation, what specific
1378 changes to Medicare's payment policy should be implemented to
1379 restore payment parity across care settings?

1380 And what impact do these payment disparities have on
1381 beneficiaries' out-of-pocket costs?

1382 *Dr. Andrews. Thank you for that question.

1383 I think being able to catch up the office-based
1384 environment with inflationary increases compared to hospitals
1385 and nursing facilities who have had that all along is really
1386 important to keeping the care, outpatient and independent
1387 practices -- especially as we have all talked about today --
1388 in rural environments open.

1389 Some other things that are really helpful, the five-year
1390 hybrid payment pilot that is in the Patients First Act, that
1391 could truly stabilize the ability to innovate care, but do
1392 the kind of care that we are talking about with phone calls,
1393 collaborating with pharmacy, with OB/GYN and other folks.

1394 *Mr. Ruiz. Thank you, thank you. You know, we also
1395 know that Medicare is a lifeline for seniors. We know that.
1396 Seniors rely on Medicare. But the reimbursements for
1397 physicians have not been keeping pace with the cost of
1398 providing that care and with the inflation. And plus, you

1399 have fluctuation costs, cuts that are happening as we speak,
1400 proposed rules. So we need to do a better job at expanding
1401 Medicare access to seniors.

1402 We need to end these end-of-year cuts, and we need to
1403 pay providers a fair reimbursement rate so they can keep
1404 their doors open because if they close their doors seniors
1405 can't see them. And that is a senior access issue. And that
1406 is why we need to tie the reimbursements to the full MEI.
1407 All the other providers have full parity for MEI
1408 reimbursements, and so that is why, you know, I introduced
1409 the Protecting Medicare for Patients and Providers Act, to
1410 tie the reimbursements to the full MEI. Representative
1411 Bilirakis is a lead cosponsor of that bill, as well.

1412 You know, there is a lot of great things in the Patients
1413 First Act, but I am a little worried that we are short-
1414 changing physicians, we are short-changing providers and
1415 trying to call it a doc fix when it is not a doc fix. It has
1416 got to be able to -- doctors have got to be able to keep
1417 their doors open. And the most simple way of reimbursing
1418 physicians for fairness is by fully matching the full MEI,
1419 just like all other providers, to have parity for physicians.

1420 So Dr. Andrews, would you prefer a full MEI
1421 reimbursement?

1422 *Dr. Andrews. I think everybody would. However --

1423 *Mr. Ruiz. Thank you. So I want to ask Dr. Alam.

1424 Would you prefer a full MEI reimbursement?

1425 *Dr. Alam. Yes, sir, but we feel the Patients First Act
1426 is a good first step. And we thank you very much for your
1427 leadership in pushing for a full MEI adjustment.

1428 *Mr. Ruiz. Great. Well, I just want to make it clear
1429 that this is going to leave an unsatisfactory sentiment
1430 amongst the provider organizations. I agree this is a good
1431 next step, but this isn't the fix. We can't stop until we
1432 have the full MEI parity.

1433 With that I yield back.

1434 *Mr. Griffith. The gentleman yields back. I now
1435 recognize the gentleman from Pennsylvania, Dr. Joyce, for his
1436 questions.

1437 *Mr. Joyce. Thank you for yielding, Mr. Chairman, and
1438 for holding today's hearing on such a critical topic.

1439 Extensive consolidation in our health care system has
1440 left the American patient facing skyrocketing costs and less
1441 access to doctors. This is driven in no small part by the
1442 death of the private practice in this country. Today only
1443 one in five doctors is not an employee of a major health
1444 system or a large corporate entity.

1445 We have left far too many seniors without access to a
1446 primary care provider and pushed more care delivery into more
1447 expensive settings through decades of declining reimbursement
1448 under the Medicare physician fee schedule. To address these

1449 issues both the GOP Doctors Caucus and the Democrat Doctors
1450 Caucus have delivered bipartisan reform to alleviate these
1451 issues to ensure better primary care access for seniors to
1452 create stability for smaller and rural practices. H.R. 9633,
1453 the Patients First Act authored by me, Dr. Schrier, and Dr.
1454 Murphy, is a necessary first step, and I am pleased to see
1455 that it is included in today's hearing.

1456 Dr. Alam, we are going to make this very simple for the
1457 first three questions.

1458 First of all, thank you for being here today. Just very
1459 simply, yes or no. Are private practice doctors the most
1460 cost-effective access points to our health care in America?

1461 *Dr. Alam. Yes.

1462 *Mr. Joyce. Dr. Alam, do you believe that consolidation
1463 reduces options for patients to receive personalized care
1464 from a doctor that they know and a doctor that they trust?

1465 *Dr. Alam. Yes.

1466 *Mr. Joyce. And finally, Dr. Alam, what do you hear
1467 from the doctors that you work with about the challenges that
1468 they face on a daily basis to remain independent?

1469 And how does the Patients First Act address their
1470 concerns?

1471 *Dr. Alam. The Patients First Act is critical, in our
1472 opinion. The biggest concern we hear from our member
1473 physicians is that Medicare reimbursement cuts are impairing

1474 their ability to see patients in a timely manner and provide
1475 necessary care. Right now, 99 percent of skin cancers are
1476 curable. If that number, because of delay, decreased by even
1477 a single percent to 98 percent, the increased number of
1478 deaths would be comparable to the number of lives saved by
1479 the use of seatbelts and airbags in the entire country.

1480 Now, none of us would be happy having our family travel
1481 in a car without seatbelts or airbags, and certainly none of
1482 us would deliberately disable those protections if that were
1483 an option. In that context, the Patients First Act is
1484 critical. It is critical because while it doesn't provide a
1485 full inflationary update, it takes a big step in the right
1486 direction at MEI minus one. It also provides for a change in
1487 budget neutrality so that if some services in the health care
1488 system are paid at a higher price, someone else doesn't have
1489 to take a pay cut that is unrealistic.

1490 And finally, it mitigates the extreme administrative
1491 burden on patients and physicians of things like MIPS, which
1492 cause doctors to be distracted with paperwork when they could
1493 be taking care of patients.

1494 We are grateful for your leadership in supporting the
1495 Patients First Act and in authoring the Patients First Act,
1496 and we are hopeful that Congress will consider this as a
1497 necessary step in improving our health care system. Thank
1498 you.

1499 *Mr. Joyce. Thank you, Dr. Alam. I would also like to
1500 thank the committee for considering legislation today from
1501 Dr. Miller-Meeks that also deals with the failing MIPS system
1502 that you just mentioned, and for Mr. Gus Bilirakis for his
1503 work on H.R. 7863, which helps support office-based providers
1504 on keeping services with costly supplies out of the hospital
1505 setting.

1506 We must all continue to work and build on these reforms
1507 and advance them by the end of the year. The annual year-end
1508 patchwork needs to stop. We must pass the comprehensive
1509 reforms contained in the Patients First Act and others that
1510 we are considering as well to ensure access to the highest
1511 quality of care that all of Americans deserve and that all of
1512 Americans want.

1513 Thank you, Mr. Chairman, and I yield the remainder of my
1514 time.

1515 *Mr. Griffith. I thank the gentleman who yields back,
1516 and I now recognize the gentlelady, Ms. Kelly, for her five
1517 minutes.

1518 *Ms. Kelly. Thank you, Chair Griffith, for convening
1519 this hearing, and thank you to all the witnesses.

1520 As the committee considers ways in which we can
1521 strengthen our health care system through provider payment
1522 reform and protect our health infrastructure, I would like to
1523 focus on the question of whether patients in this country can

1524 actually access the care they need in the first place.

1525 Maternal care has constantly been treated as an
1526 afterthought in this country, and every day women pay the
1527 price. The United States is facing a severe maternal
1528 mortality crisis. And as hundreds of women die every year
1529 from preventable pregnancy-related complications, labor and
1530 delivery units are being closed. Between 2010 and 2024
1531 alone, over 700 hospitals across the country closed their
1532 obstetrics units. These closures have mostly impacted rural
1533 areas -- have most impacted rural areas and, as a result, 58
1534 percent of rural counties lack obstetric clinicians.

1535 Pregnant and postpartum women living in these counties
1536 are left stranded, forced to travel long distances to access
1537 the critical care they need. I had a farmer tell me he had
1538 to drive 60 miles for his wife to have her baby, and she
1539 wasn't ready. He drove 60 miles back, then she was ready 60
1540 miles back.

1541 In emergency situations, every minute that care is
1542 delayed can result in catastrophic consequences. Dr.
1543 Attwood, you are a practicing OB/GYN, and you have handled
1544 emergency obstetric care directly. Firstly I would like to
1545 thank you for your critical work and thank you for your
1546 testimony today. In your experience, when an obstetric unit
1547 closes, what is the impact on the surrounding communities?

1548 *Dr. Attwood. Yes, thank you for the question and thank

1549 you for your leadership, Congresswoman.

1550 It is a very real experience for both patients and
1551 clinicians and OB/GYNs when this happens. If I can use an
1552 example, actually, just from this past weekend as well, so we
1553 have many hospitals in our area that do not have labor and
1554 delivery units and do not have OB/GYN providers within the
1555 hospital. But patients don't always know that, right? They
1556 think it is the closest hospital to their house, that is
1557 where they go.

1558 So we had a patient who presented in her early third
1559 trimester, did not know she was pregnant, and had abdominal
1560 pain. Ultimately speaking, the emergency medicine clinician
1561 there very quickly realized we are concerned about pre-term
1562 labor, and we are concerned this baby is going to deliver in
1563 a place that is not going to be suitable for that baby to
1564 come out and to be the most safe for the mom. So they were
1565 able to call us and say, hey, how can we help? What can we
1566 do?

1567 We talked them through an evaluation. We talked them

1568 through the necessary medications to help prevent infection
1569 for the infant, to help slow the contractions in order to
1570 help her safely travel to our institution, to give the
1571 medications to help that baby's lungs mature if it were to
1572 deliver.

1573 In the end, ultimately the mom was transferred to us and

1574 the baby was safely not delivered, and she was able to stay
1575 pregnant because we had all of those tools at our disposal,
1576 including the warm line that they were able to call. And so
1577 whereas we, of course, would always like our patients to have
1578 the fastest access to OB/GYNs, we know that is not always the
1579 case. And the Rural Obstetrics Readiness Act really helps
1580 bridge that gap to be able to provide that care when needed.

1581 *Ms. Kelly. Thank you. I introduce a bipartisan Rural
1582 Obstetrics Readiness Act alongside my colleagues,
1583 Representative Schrier, Kim, and Meuser to work to address
1584 the widening gap in maternity care. As you noted in your
1585 testimony, in areas where there is no obstetric services
1586 emergency departments and other health care facilities play a
1587 vital role in maternal and infant health, but they are not
1588 always equipped to take on the most severe cases.

1589 So for facilities in rural areas without obstetric
1590 units, how can training and equipment help bridge the gap to
1591 stabilize an obstetrics emergency? And I only have a little
1592 bit of time.

1593 *Dr. Attwood. Yes, it is -- training is so important,
1594 and having the necessary equipment is also really -- a really
1595 important piece of that puzzle. And so being able to work
1596 directly with the trainees in emergency medicine, family
1597 medicine, nurse practitioners like I stated earlier, is the
1598 first step. And then making sure they have the tools in

1599 their institution.

1600 These tools might be hemorrhage cart materials or to
1601 manage infant warmers, a bedside ultrasound that they might
1602 not have or might not have the training to have, teaching
1603 them to be able to locate where is that baby? What is the
1604 heart rate? Can we safely deliver this baby? You know,
1605 other important things like specialized anesthesia equipment
1606 which is not always the same for a pregnant mom, emergency
1607 delivery equipment, even beds that support delivery in an
1608 emergency department which most places don't have, making
1609 sure we have that available so when those patients do present
1610 in acute settings that we have the supplies they need to be
1611 safely managed prior to transfer.

1612 *Ms. Kelly. Thank you. Well, this is just one step in
1613 the right direction in addressing the U.S. maternal mortality
1614 crisis. Access to these resources can mean life or death for
1615 rural moms, and I urge my colleagues to please, please,
1616 please help me push this legislation forward. I just wanted
1617 to give my support for H.R. 9693.

1618 Thank you, and I yield back.

1619 *Mr. Griffith. Thank you, I appreciate it. I now
1620 recognize the gentleman from Oregon, Mr. Bentz, for his five
1621 minutes.

1622 *Mr. Bentz. Well, thank you, Mr. Chair, and I also want
1623 to talk about H.R. 1254.

1624 We -- in my second-largest district that is not a state
1625 in the United States, 70,000 square miles, we have a huge
1626 challenge when it comes to obstetrics. And in fact, in
1627 Little Baker City, Oregon we have just lost our obstetrics
1628 department, which means that anyone presenting there has to
1629 drive 45 miles to the closest place, and perhaps further if
1630 you go the other direction. So this legislation is of
1631 incredible interest to me for those reasons and others across
1632 the district.

1633 One of the -- I am a lawyer, and I represented hospitals
1634 and doctors in medical malpractice suits. And the cost of
1635 obstetric coverage is a lot, about \$150,000 a year. So I am
1636 curious, Doctor, the -- Attwood. The challenge of training
1637 people up is one thing, but it is quite another then to have
1638 the money to pay for the coverage necessary. Can you share
1639 your thoughts on what we might do in being able to actually
1640 afford to have people try to practice obstetrics when they
1641 are trained up, but not really a doctor?

1642 *Dr. Attwood. Yes, thank you for that.

1643 You know, it was mentioned earlier about the number of
1644 patients who are having deliveries that are paid for by
1645 Medicaid. It is about -- a little over 40 percent in the
1646 United States of births are paid for by Medicaid. And
1647 ultimately, we know that Medicare informs the Medicaid pay
1648 rates.

1649 So one of the key parts of keeping labor and delivery
1650 unit closures -- and this is a multi-factorial problem with
1651 lots of financial pressures, right, as you -- the costs are
1652 difficult to cover, there is the high cost of malpractice
1653 insurance as you mentioned, lower birth rates in rural areas.
1654 Ultimately, it is very difficult and costly for around-the-
1655 clock OB staffing. But if we can help to stabilize, in all
1656 honesty, the Medicare payment, that will hopefully help to
1657 influence and inform the Medicare-Medicaid payment rates that
1658 will ideally be one of the many solutions we can have to
1659 keeping these labor and delivery units open across our
1660 nation.

1661 *Mr. Bentz. And actually, the question that I have had
1662 -- and when I was in the Oregon Legislature we addressed this
1663 issue, never successfully, was in some fashion trying to
1664 provide protection to the OBs that were practicing in these
1665 spaces and saying, hey, these risks are extremely difficult
1666 to manage, particularly if you don't have an OB physician on
1667 staff, and particularly if you are trying to hold the
1668 situation stable as you are driving literally -- not
1669 necessarily hundreds of miles, but it is possible.

1670 And this brings us to the attempts that we have made in
1671 the big, beautiful bill to put millions of dollars into these
1672 rural hospitals to try to help. But we have created
1673 different situations in our tort law that makes the error

1674 that may occur in that process extremely attractive to
1675 lawyers. And frankly, the damage is so great when a little
1676 newborn is harmed, it is difficult to even recognize how in
1677 the world one is going to pay those bills.

1678 What I am trying to get at here is, is this enough that
1679 we train these people up, or do we need to broaden the scope
1680 of this bill or add to it after -- I hope it passes -- to
1681 address this tort liability problem?

1682 *Dr. Attwood. You know, I appreciate the emphasis on
1683 the importance of the Rural Obstetrics Readiness Act and how
1684 it really does help to provide -- fill in the gap of when
1685 there is not an OB/GYN available.

1686 And, you know, certainly we want more obstetric
1687 providers across the country to be able to be in those
1688 spaces, to be able to work in those hospitals. We want to
1689 work with our colleagues across the house of medicine to be
1690 able to safely manage obstetric emergencies and we want to
1691 work with Congress to be able to get this bill across the
1692 finish line.

1693 *Mr. Bentz. The bill also contains a pilot program for
1694 teleconsultation, and this has been something that is coming
1695 up again and again in rural areas in all kinds of practice
1696 areas. But the challenge always is who is the doctor going
1697 to be on the -- that is going to be called and to opine over
1698 the line, so to speak. So what is your thought there?

1699 Should we be addressing more than merely the provision of the
1700 equipment?

1701 Because I know it does say you have to have qualified
1702 physicians on -- providing the information over the line, but
1703 would you, as a doctor, want to be opening yourself up to
1704 liability as the one who instructs folks over the line, so to
1705 speak?

1706 *Dr. Attwood. Well, certainly teleconsultation has been
1707 done in other settings. For example, telestroke is available
1708 for stroke patients. And so there is opportunities to look
1709 at this.

1710 I mean, in Rhode Island we have functionally -- well, a
1711 literal phone that everyone knows that they can call to that
1712 perinatal safety officer, that they can get them 24/7 to be
1713 able to move that patient and get a hold of that. So I
1714 think, as you develop those relationships and we develop the
1715 training programs, it is an important part of how we think
1716 through the operations and the implementation of this bill
1717 when we get to that point, hopefully.

1718 *Mr. Bentz. Thank you so much.

1719 I yield back.

1720 *Mr. Griffith. The gentleman yields back. I now
1721 recognize the gentlelady, Dr. Schrier, for her five minutes.

1722 *Ms. Schrier. Thank you, Mr. Chairman and Ranking
1723 Member and witnesses. I am excited about several bills

1724 today.

1725 The first I want to talk about is the bill that I lead
1726 with Congresswoman Kelly, H.R. 1254, the Rural Obstetrics
1727 Readiness Act. It is included in today's hearing, and I will
1728 tell you that in the wake of the \$1 trillion cut to Medicaid,
1729 rural hospitals are going to be pushed to the brink of
1730 closure. Many of them are already there, and the first thing
1731 to close is labor and delivery. And this bill is critical to
1732 keeping those moms and babies safe.

1733 Now I want to pivot to the Patients First Act, as you, I
1734 am sure, are not surprised. I am so thrilled that this
1735 committee is considering my bill, the Patients First Act.
1736 For the last year -- or over a year, Congresswoman --
1737 Congressman John Joyce and I have been working together on
1738 this bipartisan Medicare physician reimbursement package that
1739 stabilizes Medicare payment, invests in primary care, and
1740 reduces administrative burden for doctors. This is long
1741 overdue.

1742 I have heard criticism in this hearing that this doesn't
1743 go far enough, but this is a great bill. And what we do here
1744 in Washington, D.C. is all about the art of the possible.

1745 This product is the result of consensus between Democrats and
1746 Republicans, doctors, specialty physicians, primary care
1747 doctors, consumer groups, patients, and more. We have broad
1748 support from bipartisan members on this committee and in Ways

1749 and Means. We have been able to gain this support for a
1750 simple reason: fair reimbursement respects the work that
1751 physicians do and keeps practices open and available to
1752 patients so that seniors can get the care that they need.

1753 And our bill tackles more than just stabilizing payment.
1754 We invest in the desperately needed primary care that is so
1755 foundational to wellness and managing chronic diseases. And
1756 we also reduce administrative burden in the MIPS quality
1757 program.

1758 Thank you, Dr. Andrews, for your work and for painting
1759 such a beautiful picture of what primary care physicians do
1760 for our patients over decades.

1761 Quality metrics known as MIPS were really well
1762 intentioned, but they have led to overwhelmingly burdensome
1763 administrative responsibilities, like 53 hours and almost
1764 \$13,000 per physician per year to do this paperwork, and yet
1765 with no clear improvements in outcomes. And if the doctors
1766 don't meet those metrics, they get penalized. And
1767 unsurprisingly, if you are a small practice in a rural area
1768 and you can't take on the administrative burden that a big
1769 hospital can, then you get penalized. And then that makes
1770 them more likely to get gobbled up by a giant system or
1771 private equity.

1772 Dr. Alam, can you speak to the MIPS measures just
1773 briefly that exist for dermatology, and whether they even

1774 apply to your specialty or measure actual quality?

1775 *Dr. Alam. Thank you for that question. I think the
1776 simple answer is they do not.

1777 I think many measures are developed because they are
1778 simple to measure or because some organization thought they
1779 might be a good idea. But the doctors involved who are
1780 dealing with patients on a daily basis are very seldom
1781 consulted. And while we spend a lot of time tracking these
1782 measures and reporting them, like you said, it doesn't really
1783 help patients get better care.

1784 *Ms. Schrier. That is right. And we hear that across
1785 the board, and that is why this bill makes sure that it is
1786 the physicians who are determining what are the best metrics
1787 to measure quality, and that those are reevaluated
1788 frequently. That is so critical.

1789 I just want to say it is time for Congress to finally
1790 right this ship and to enact long-term reform to physician
1791 payment. We can't pass yet another short-term fix and leave
1792 everybody on edge until the end of the year like we have done
1793 for so many years. Without Patients First, physician
1794 practices will continue to close or be bought out by large
1795 hospital systems, private equity, or insurance companies, and
1796 that just raises the cost of care for everyone. And without
1797 support for primary care, we can expect to see fewer and
1798 fewer medical students pursue that path.

1799 I urge this committee to move this legislation straight
1800 to markup. We need to pass the Patients First Act
1801 immediately.

1802 Thank you. I yield back.

1803 *Mr. Griffith. The gentlelady yields back, and I will

1804 now recognize the gentleman from Ohio, Mr. Balderson.

1805 *Mr. Balderson. Thank you, Mr. Chairman, and thank you
1806 all for being here today. My first question is for Dr.
1807 Pudlo.

1808 How are you this morning, sir? This afternoon now. I
1809 am a proud cosponsor of H.R. 3164, the Ensuring Community
1810 Access to Pharmaceutical Services Act.

1811 In many rural communities the local pharmacy is the
1812 closest and most accessible place to receive care. This bill
1813 would allow Medicare to cover tests for respiratory illnesses
1814 like RSV and strep throat when permitted by state law. How
1815 would this common-sense change help seniors get care sooner
1816 and avoid unnecessary trips to the emergency room?

1817 *Dr. Pudlo. Thank you for your question, Congressman.
1818 I would completely agree with your assumption and what we are
1819 trying to do with the piece of legislation.

1820 H.R. 3164 is about giving seniors access, first and
1821 foremost. Pharmacists already are, especially in --
1822 Tennessee and multiple other states already have this
1823 authority. We are just needing to make sure there is a

1824 payment mechanism behind it. And so right now we see
1825 pharmacists doing this on a regular basis across this
1826 country, and it is about helping them go through a more
1827 convenient location instead of going through a more higher-
1828 cost location, say like an emergency department.

1829 *Mr. Balderson. Thank you. And my rural pharmacists
1830 love this too, as you would assume.

1831 My next question is for Dr. Alam. Doctor, good to see
1832 you here. My next question is for you, sir. You noted in
1833 your testimony significant concerns about MIPS and the
1834 administrative burdens it places on physicians. What reforms
1835 could Congress consider to improve the program for
1836 specialists?

1837 *Dr. Alam. I think to improve the program for
1838 specialists, the specialists should be involved in the
1839 process of developing the measures and better understanding
1840 -- first of all, more research into understanding what does
1841 improve quality, and then finding ways to incorporate that in
1842 the routine delivery of care.

1843 I think the current system is predicated on a simple
1844 solution to a difficult problem, which is how to improve
1845 quality. And while it is well-intentioned, as Congresswoman
1846 Schrier indicated, it is not meeting those goals. I think we
1847 have to go back to the beginning, involve patients from
1848 different specialties, say what is it that would make your

1849 patients healthier, how could we get them more effective
1850 care, and then implement that.

1851 *Mr. Balderson. Thank you, sir. A follow-up to that.
1852 What roles could clinical data registries play in these
1853 reforms?

1854 *Dr. Alam. Clinical data registries are very important
1855 not only for reporting MIPS as it currently stands, but also
1856 for understanding better the quality of care that is
1857 delivered and doing research, and to understanding what
1858 works.

1859 In dermatology we have such a registry called DataDerm
1860 that has been around since 2016 and has about 70 million
1861 encounters. And many other specialties have these, as well.
1862 Using those as a building block to better understand what
1863 works for our patients will be very helpful in developing
1864 better measures.

1865 *Mr. Balderson. Thank you very much, sir. My next
1866 question is for Dr. Andrews.

1867 Good afternoon, Dr. Andrews. H.R. 6130, the Alzheimer's
1868 Screening and Prevention Act, would provide Medicare coverage
1869 for blood-based tests that detect Alzheimer's disease and
1870 related dementias at an early stage. How can Congress
1871 balance investments in early detection with continued funding
1872 for research into effective treatments and a cure?

1873 *Dr. Andrews. Thank you, and good afternoon.

1874 I think that Alzheimer's -- you know, the American
1875 College of Physicians, we treat all chronic conditions. And
1876 diagnosing them as early as possible and finding treatments
1877 that work for them are an investment that, as you said, needs
1878 to be balanced.

1879 But when we are preventing downstream effects, whether
1880 it is leaving a patient without access or causing high-cost
1881 admissions because we haven't diagnosed the cause of
1882 something, the Patients First Act along with looking at, as
1883 my colleague Dr. Alam said, what works for patients, what
1884 kind of quality outcomes do we have would be a way to balance
1885 that, so making sure that treatments do what they are
1886 supposed to do and that we can get them to patients as early
1887 as possible with diagnosis.

1888 *Mr. Balderson. Thank you very much. My last question
1889 is for Mr. Garcia.

1890 And we have about 30 seconds, sir. Rural and smaller
1891 hospitals face serious cyber threats, but often lack the
1892 staffing resources of the larger health care systems. How
1893 can Congress help these hospitals strengthen their
1894 cybersecurity without imposing unnecessary requirements?

1895 *Mr. Garcia. Well, I think that is a very good
1896 question, Congressman.

1897 I think congressional funding to assist rural -- the
1898 nation's rural hospitals for the kinds of workforce and

1899 technology needs that will help secure them, and also
1900 building mutual assistance support across communities in
1901 rural areas. I think there is strength in numbers.

1902 And we produced a report called "On the Edge," which
1903 interviewed 40 executives and rural providers across 30
1904 states and, really, workforce was probably their number-one
1905 need. They knew what needed to be done. They know what
1906 needs to be done in cybersecurity, but they don't have the
1907 expertise, the resources, and the people.

1908 *Mr. Balderson. Thank you very much, Mr. Chairman, I
1909 yield back.

1910 *Mr. Griffith. The gentleman yields back. I now
1911 recognize Mr. Landsman for his five minutes.

1912 *Mr. Landsman. Thank you, Mr. Chair, and thank you to
1913 you and the ranking member for this hearing today. I wanted
1914 to say how much I appreciated the testimony for each of our
1915 witnesses.

1916 I am very supportive of the Patients First Act. I want
1917 to thank my colleagues for leading this. And all of the
1918 additional suggestions around physician pay, I think, are
1919 really important. I am going to get into those a little bit
1920 more.

1921 The National Plan for Epilepsy Act, I just want to say
1922 how important that is. And Gabi, I really appreciated your
1923 testimony and your family being here today. I know this

1924 isn't easy, and I found it to be so incredibly compelling.

1925 And obviously, this is something we need to act on.

1926 The Rural Obstetrician -- sorry -- Readiness Act is so
1927 incredibly important. The piece I want to get into today is
1928 around pay, and what is at the core of this health care
1929 crisis, the fact that costs are skyrocketing, care is
1930 diminishing, the ability to see a doctor is becoming more and
1931 more problematic. And there are three things that Congress
1932 has not done.

1933 One is obviously kept up with physician pay. Congress
1934 has decided not to pay physicians what they need to be paid,
1935 and that combined with the fact that Congress has decided
1936 that physicians will get paid less if they do it on their own
1937 as opposed to if they do it with a hospital. So Congress has
1938 said we are going to pay hospitals more for the exact same
1939 procedure if the procedure is done with a hospital as opposed
1940 to if it is an independent, physician-owned practice. And
1941 then three, Congress has refused to rein in private equity,
1942 Wall Street, and the consolidation that is happening
1943 throughout the entire economy, but certainly health care.
1944 And all of this has conspired to, you know, to increase
1945 costs, huge cost increases for patients.

1946 The Kettering Foundation tells a story -- and it is
1947 emblematic of stories I hear all the time -- of a patient in
1948 Ohio who had a procedure. And if that procedure had been

1949 done with the physician that she found in the physician's
1950 office, it would cost \$3,000. But because of who owned the
1951 surgery center and where the insurer wanted this procedure to
1952 be taking place, it was taking place at a hospital for
1953 \$6,000. So she ended up paying \$3,000 more because of this.

1954 And I hear this from physicians all the time, which is,
1955 "When I was on my own I charged \$800. But now that I got
1956 bought up and I work now for the hospital or this insurance
1957 company or a private equity firm, it costs patients \$2,600, 2
1958 to 3 to 4 times more.'" This is at the heart of this health
1959 care crisis.

1960 You know, how we got here, I think, is really important.
1961 Congress has not updated the Medicare physician fee schedule
1962 since 2015. The American Medical Association estimates that
1963 between 2001 and 2025, physician pay for Medicare increased
1964 by 7 percent, while medical practice costs rose by 59
1965 percent. Physician payments have dropped by 33 percent since
1966 2001, as we have heard. As of January 6 -- January of this
1967 year, 64 percent of all physician practices were owned by
1968 hospitals or corporate entities; 82 percent of all doctors
1969 now work for the hospital, a corporation, the insurer, or
1970 private equity; 82 percent of all doctors. Investors are
1971 coming in and buying up our local clinics, hospitals, and
1972 doctor's offices. This has obviously led to skyrocketing
1973 costs.

1974 Dr. Alam, dermatology is obviously a place this has been
1975 hit. If Congress does not improve reimbursement rates, rein
1976 in private equity, change the way we reimburse doctors or
1977 hospitals, what will be the impact of patient care?

1978 *Dr. Alam. The impact on patient care will be fewer
1979 places to find a doctor, much longer waits, dramatically
1980 worsened disease processes, advanced cancers, deaths that are
1981 avoidable, all the things that you already mentioned.

1982 We don't really know what we are going to do. How are
1983 we going to deliver the services that our patients need when
1984 costs keep going up every year and we are paid less every
1985 year? We support practices, we support staff, we need space.
1986 All of that costs money.

1987 *Mr. Landsman. Thank you.

1988 Mr. Chair, Congress needs to increase the reimbursement
1989 rates for physicians. Congress needs to rein in Wall Street
1990 and private equity and stop the consolidation, break this
1991 stuff up, and Congress needs to stop paying hospitals more
1992 money for the exact same procedure if it is done at a
1993 hospital versus a privately-owned doctor-owned physician
1994 clinic. Thank you, and I yield back.

1995 *Mr. Griffith. The gentleman yields back. I now
1996 recognize the chairman of the full committee, Mr. Guthrie,
1997 for his questioning.

1998 *The Chair. Thank you. Thank you very much. I know we

1999 have a couple of hearings going on, so I have been in and
2000 out, so I may ask some stuff that you have kind of touched on
2001 earlier, but it would be good to kind of frame it -- frame
2002 the question and get a more elaborate answer or elaboration.

2003 So Dr. Alam and Andrews, MACRA was signed into law over
2004 a decade ago with the goal of moving past the need to enact
2005 annual doc fixes and transitioning the Medicare program to
2006 value-based care. Yet many of these issues still persist.
2007 We are looking at an annual doc fix coming up. Could you
2008 speak to how many of the -- so Dr. Alam then Dr. Andrews, how
2009 many of the reforms being discussed would address these
2010 challenges?

2011 And what do the reforms ultimately mean for citizens'
2012 access to care?

2013 *Dr. Alam. I think many of the reforms in the Patient
2014 First Act would address some of these challenges.

2015 One big problem that has been highlighted is there has
2016 really not been an inflation adjustment since about 2001. So
2017 25 years of inflation rising but costs remaining the same,
2018 reimbursements remaining the same, is a big problem.

2019 Another big problem is budget neutrality. Budget
2020 neutrality means the pie is of a fixed size. If some part of
2021 the medical system is paid a little more, some practitioners
2022 paid a little more, someone else has to take a pay cut. When
2023 the overall pie is shrinking based on inflation anyway, that

2024 sort of double hit makes it even harder for practitioners.

2025 And then finally, as we have heard, there are many
2026 administrative rules that are burdening patients, making it
2027 harder for them to spend their limited time seeing patients,
2028 and are in fact forcing consolidation because independent
2029 practices just cannot meet these administrative burdens.

2030 So we are hopeful that your committee and Congress will
2031 consider the Patient First Act since, while it doesn't solve
2032 every problem, we think it is a very important step to
2033 mitigating this decades-long erosion of our capacity to take
2034 care of patients.

2035 *The Chair. Okay, Dr. Andrews?

2036 *Dr. Andrews. I concur 100 percent, especially with the
2037 fact that this is one of the first acts which allows all

2038 physicians of all specialties to work together instead of
2039 pitting one loss versus one gain.

2040 A couple of the other things that the Patients First Act
2041 does that is really important is this five-year hybrid
2042 payment that will allow for primary care to not only have fee
2043 for service, but also a separate payment that will help us do
2044 the things that we know actually matter. If my pharmacist
2045 from my office calls patients and makes sure they are taking
2046 their medications, that helps them stay out of the hospital.
2047 But I need a way to be able to pay for that. And so that
2048 allows for innovation that truly improves quality.

2049 And then I think we are all in agreement today that
2050 having clinicians and physician organizations able to
2051 influence the quality measures that we are looking at is
2052 really important. Let's measure what matters, what produces
2053 longer lives and healthier patients.

2054 *The Chair. Okay, thanks. And so you talked to
2055 pharmacy, as well, so I am going to switch to Dr. Pudlo.

2056 As this committee considers policies to modernize the
2057 Medicare payment policies, what role can pharmacists play in
2058 enhancing seniors' ability to get care they need, especially
2059 in, like I have, rural areas?

2060 *Dr. Pudlo. Yes, thank you for your -- for the
2061 question, Chairman. I will kind of piggyback a little bit
2062 off of Dr. Andrews, as well, because there is a lot of
2063 different ways that pharmacists can provide services in the
2064 system.

2065 But I know specifically I am here -- I want to really
2066 emphasize again the valuable role of H.R. 3164. That alone,
2067 that type of service that is already happening for a lot of
2068 patients in your state -- where there is compensation from
2069 Medicaid and commercial plans but not Medicare, that is a
2070 problem. And 3164 is really ultimately a cost solution for
2071 Medicare. It is letting -- if a senior is not getting this
2072 service paid for, they are going to an emergency room that is
2073 much more costly, they are facing the bill, we need to have

2074 coverage on the state level for the services that pharmacists
2075 are allowed to provide.

2076 *The Chair. Thank you. Yes, I agree, there is --
2077 pharmacists could be miles, hours away from a local medical
2078 health medical provider or health care facility. And they
2079 are all -- in all communities, so it is important to do.

2080 So Mr. Garcia, before we go, so we talked about
2081 regulatory burdens and paperwork burdens and all the other.
2082 So the Health Care Cybersecurity and Resiliency Act before us
2083 today includes several more policies to coordinate planning
2084 HHS for cybersecurity. Are there any additional policies you
2085 believe would further enhance HHS's ability to address
2086 healthcare cybersecurity without risking duplication or
2087 excess burdens on the providers?

2088 *Mr. Garcia. No, I don't think there is more regulation
2089 needed on the health care sector.

2090 One of the areas that is most essential to us is the
2091 fact that so many of these health care providers and large
2092 hospitals are depending on third-party technology and
2093 services that are not regulated, that are not held to higher
2094 cybersecurity standards, particularly for critical
2095 infrastructure industries like health care. And the end
2096 result of that is my colleagues here on the panel and other
2097 hospitals are left holding the bag when the technology goes
2098 dark.

2099 And so I think we need -- and it is not just HHS's
2100 responsibility or CISA, but we need to think holistically
2101 about how we can --

2102 *The Chair. I asked you a long question and didn't give
2103 you much time to respond. I absolutely --

2104 *Mr. Garcia. I am sorry, I am sorry.

2105 *The Chair. I hate doing that, I hate when people do

2106 that when I am sitting in the chair, so I apologize and I
2107 will yield back.

2108 *Mr. Griffith. The gentleman yields back and -- do you
2109 want me to go to Mrs. Houchin first?

2110 *Voice. No, I don't mind a bit.

2111 *Mr. Griffith. I recognize the gentlelady from Indiana,
2112 Mrs. Houchin, for her five minutes of questioning.

2113 *Mrs. Houchin. Thank you, Mr. Chairman, and thank you
2114 to the witnesses for being here today.

2115 Our nation's hospitals are facing increasingly serious
2116 cybersecurity threats. Ensuring that the health care system
2117 has the tools and safeguards necessary to protect against
2118 these malicious actions are critical. Every cyber attack has
2119 the potential to impact hundreds, thousands, or even millions
2120 of individuals. And in health care the consequences go much
2121 farther than a simple stolen password or a compromised
2122 computer system.

2123 Recent cyber attacks, including those in my district,

2124 have resulted in canceled surgeries and appointments, payment
2125 system outages, and even an inability to provide emergency
2126 care. The Department of Health and Human Services has
2127 reported a staggering 329 reported breaches this year
2128 involving hacking or information technology incidents at
2129 health care providers and health plans. These threats pose
2130 even greater risks to rural hospitals, which may serve as the
2131 only source of care for miles and often have fewer financial
2132 and personal -- personnel resources to prevent and respond to
2133 cyber attacks.

2134 And the reported breaches are only those of a greater
2135 than 500 patient impact. That is why I am pleased to see
2136 H.R. 9908, the Rural Hospital Cybersecurity Enhancement Act,
2137 included in today's hearing, and I want to thank my
2138 colleague, Congresswoman Schrier, for her partnership on this
2139 bipartisan bill. Our bill takes a targeted approach by
2140 directing HHS to develop a comprehensive rural hospital
2141 cybersecurity workforce strategy, expand cybersecurity
2142 training resources, and improve preparedness against these
2143 growing threats.

2144 Mr. Garcia, in your testimony you emphasized the
2145 importance of structured coordination between HHS and CISA
2146 and the health care sector. How could this bill improve that
2147 coordination between the entities, and what gaps are there in
2148 the current Federal response that this legislation could

2149 address?

2150 *Mr. Garcia. Well, I can tell you that HHS and the
2151 sector counsel are very well focused on the rural health care
2152 issue and the resource constrained, not just rural, those
2153 that just don't have the resources.

2154 I think there is a lot that the government can do to
2155 help, but there is also work being done on the private sector
2156 side in the form of mutual assistance and partnership. And I
2157 will highlight one issue for the congresswoman from Texas,
2158 that there is an initiative going on right now called Secure
2159 Texas in which they are looking to improve the
2160 interoperability and security of health care data, and they
2161 are using an accreditation system to train people, young
2162 students in college, to learn good health care cybersecurity
2163 using the tools that my council has produced, accrediting
2164 them, and then placing them in health care organizations,
2165 particularly rural and resource-constrained providers.

2166 So that is a good example of where government and
2167 industry -- in this case state government -- are working
2168 together to help rural providers.

2169 *Mrs. Houchin. Great, thank you, and I want to turn to
2170 the Patients First Act, H.R. 9693. This will provide much-
2171 needed stability and predictability into the Medicare
2172 physician fee schedule while also improving incentives for
2173 value-based care. I am proud to cosponsor this legislation,

2174 and I am grateful to Dr. Joyce for his leadership on this
2175 important issue.

2176 Dr. Andrews, in your testimony you highlight how
2177 essential a healthy primary care physician workforce is to
2178 improving patient outcomes. What would the reforms proposed
2179 in this bill mean for primary and independent providers,
2180 especially in rural areas?

2181 And in what other line of work do we pay people less if
2182 they are more efficient in doing their jobs?

2183 *Dr. Andrews. That is a great question. I guess the
2184 same kind of industry where you can bill and then have it
2185 automatically downcoded and sent back to you for less
2186 reimbursement.

2187 You know, the Patients First Act, I have to say again,
2188 is the first bit of hope I have had in a long time for
2189 primary care, especially the independent practices that
2190 produce just absurdly great outcomes for their patients.
2191 Being able to have this stable payment both from the
2192 physician fee schedule but also correcting the, you know,
2193 three decades of inflationary losses, will really allow a
2194 stable business model for people to open their own practices
2195 and just those who are in practice to continue.

2196 *Mrs. Houchin. Thank you.

2197 *Dr. Andrews. And then I love the part about, you know,
2198 paying them for --

2199 *Mrs. Houchin. Yes.

2200 *Dr. Andrews. -- innovation.

2201 *Mrs. Houchin. Yes, thank you. In the remaining time I
2202 have I just want to note that in the Working Families Tax
2203 Cuts Act, we did include a fix for the physician fee schedule
2204 which was subsequently supplanted by the efficiency
2205 adjustments, which I hope that we will soon correct. And I
2206 am proud to see this legislation as a subject of this hearing
2207 today.

2208 Thank you. I yield back.

2209 *Mr. Griffith. And the gentlelady yields back. Now I
2210 recognize the gentleman from Georgia, Mr. Carter.

2211 *Mr. Carter of Georgia. Thank you, Mr. Chairman. Mr.

2212 Chairman, before I begin I would like to ask that --
2213 unanimous consent to enter into the record supportive
2214 statements from the National Consumers League, the Patients
2215 Rising, and nearly a dozen other national patient, consumer,
2216 and provider advocacy organizations.

2217 *Mr. Griffith. Without objection, so ordered.

2218 [The information follows:]

2219

2220 *****COMMITTEE INSERT*****

2221

2222 *Mr. Carter of Georgia. Thank you, thank you.

2223 First of all, I want to express my thanks to my
2224 colleagues, particularly on both sides of the aisle,
2225 particularly to the gentlelady from New York, Congresswoman
2226 Clarke, who has for nearly a decade worked with me on needed
2227 vision benefit manager reforms. And I am saying VPM, V as in
2228 vision. Many of you know me as Mr. PBM, and I am not talking
2229 about PBMs in this case; I am talking about VBMs.

2230 National surveys showed that health care affordability
2231 and control of important health decisions remain one of the
2232 top topic topics that people are concerned about. And the
2233 growing insurer consolidation that I have pointed out in
2234 pharmacy is also spreading in other parts of health care as
2235 well, including in vision management. It is making our
2236 health care too expensive and too restrictive.

2237 Dr. Alam and Dr. Andrews, both of you have testified
2238 that payment pressure and administrative burdens are pushing
2239 independent practices towards consolidation. Dr. Alam, when
2240 independent practices disappear, what changes for patients in
2241 term of access, choice, and cost did this create?

2242 *Dr. Alam. When independent practices disappear, people
2243 first have to travel very often further, because some of the
2244 first independent practices to go away are those in rural
2245 areas. And also, when there is consolidation, there is less
2246 incentive for those large practices to even develop areas --

2247 in rural areas which are often less profitable.

2248 In addition, because there are fewer places overall,
2249 people have to wait in line to get an opportunity to go
2250 there, which means they are often going to have more advanced
2251 disease, have suffering, and often have irreversible harm
2252 that could have been prevented had they seen someone sooner.

2253 *Mr. Carter of Georgia. Right.

2254 *Dr. Alam. And then finally, of course, the costs go up
2255 because the consolidated entities are very good at
2256 negotiating higher rates with commercial insurers and
2257 creating other barriers to care.

2258 *Mr. Carter of Georgia. In other words, what we need is
2259 more competition.

2260 Dr. Andrews, do you want to comment on this?

2261 *Dr. Andrews. I do. I would agree that when we close
2262 practices and patients have to drive farther and they have to
2263 give up workdays and their own income, that means that they
2264 are going to present less frequently for control of their
2265 diseases which means they are going to cost the whole system.

2266 But more importantly, their quality of life is not going
2267 to be what it could be. So supporting independent practices,
2268 being able to stabilize the physician fee schedule would go a
2269 long way to enhancing, especially in those areas where staff
2270 cost more, such as those rural environments.

2271 *Mr. Carter of Georgia. And, you know, I have often

2272 said that at the end of the day, whether you are a Republican
2273 or a Democrat or an independent, we all want the same thing
2274 when it comes to health care. We want affordable,
2275 accessible, quality health care. And accessibility is being
2276 impacted by consolidation, you know, particularly in the
2277 rural areas, as you point out.

2278 And I have seen it in pharmacy. Pharmacists are the
2279 most accessible health care professionals in America. Almost
2280 88 percent of all Americans live within 5 miles of a
2281 pharmacy. As pharmacies begin to close as a result of the

2282 PBM pressures that are put on them, then we impact
2283 accessibility to health care.

2284 I would also be remiss if I did not mention the funding
2285 that we put in the Working Families Tax Cuts Act to help
2286 rural hospitals. That helps accessibility, so that is very
2287 important.

2288 I want to talk mainly today about vision benefit
2289 managers, as I said, because this is something that has
2290 happened that is through the consolidation and it is highly
2291 concentrated. There are two dominant vision benefit managers
2292 that cover roughly 85 percent of the 220 Americans with
2293 vision benefits.

2294 Now, we all know that vision insurance is important. We
2295 appreciate it. But at the same time, when you have got this
2296 kind of concentration, it does not lead to competition, and

2297 therefore it leads to an increase in prices, a decrease in
2298 accessibility, which is not what we want.

2299 Dr. Attwood, you testified that the current Medicare
2300 payment system has contributed to physician practice
2301 consolidation. How do you -- how do unstable reimbursement
2302 and take-it-or-leave-it payer contracts affect a small
2303 practice's ability to remain independent?

2304 *Dr. Attwood. Similar to what my other colleagues have
2305 said, you know, as the payment cuts have gone into effect
2306 over the course of time, we have seen how that has occurred
2307 over the past 25 years. It doesn't have increasing
2308 consolidation of physician practices, which include OB/GYN
2309 physician practices who do take care of Medicare patients as
2310 well.

2311 *Mr. Carter of Georgia. Absolutely. I want to end on
2312 one note. I had the opportunity during a hearing -- not a
2313 hearing, but a meeting of this committee of the -- not the
2314 Health Subcommittee, but the Full Energy and Commerce
2315 Committee, and the CBO, the Congressional Budget Office. We
2316 had the director and we had 20 of their staff members there.
2317 I asked them directly, "Give me one example of where
2318 consolidation in health care has decreased cost.'" They
2319 could not give me one example.

2320 Folks, we have got to do something about this,
2321 particularly in vision management, particularly in pharmacy

2322 management. Otherwise, health care costs are never going to
2323 come down and accessibility is going to be impacted, as well.

2324 Thank you, Mr. Chairman, and I yield back.

2325 *Mr. Griffith. The gentleman yields back. I now
2326 recognize the gentlelady from California, Ms. Barragan.

2327 *Ms. Barragan. Thank you, Mr. Chairman.

2328 Today, if a senior with Medicare sees a nurse
2329 practitioner or a physician's assistant for their diabetes
2330 care, they must go through a complicated process to get
2331 therapeutic shoes that help prevent diabetic foot ulcers.
2332 This means delays that leave patients at a higher risk of
2333 more serious health complications and more expensive care.
2334 That is one of the reasons I am proud to cosponsor -- that is
2335 that is one of the reasons I am glad the Promoting Access to
2336 Diabetic Shoes Act is included today, which I introduced with
2337 Representative LaHood to remove administrative barriers so
2338 that seniors can more easily access diabetic shoes that they
2339 need.

2340 So with that I would like to submit for the record a
2341 letter of support from 25 organizations.

2342 *Mr. Griffith. Without objection --

2343 *Ms. Barragan. Thank you.

2344 *Mr. Griffith. -- so ordered.

2345 [The information follows:]

2346

2347 *****COMMITTEE INSERT*****

2348

2349 *Ms. Barragan. Thank you. I look forward to working
2350 with the committee to advance that bill.

2351 Dr. Pudlo, you mentioned in your testimony that
2352 pharmacists are among the most accessible health care
2353 professionals in America. And for seniors, pharmacists are
2354 often the health care professional they see most frequently,
2355 the medication experts they trust most, and a critical member
2356 of their care team. I know personally my father had
2357 Parkinson's when I was growing up, and we always went to this
2358 local pharmacy. We could just walk right in, we saw him, he
2359 knew our name. If there was ever a problem, we were short
2360 one pill, he could advance it, and it was really great
2361 service. It was something that 50 years later I can walk
2362 into that same pharmacy and get that type of service.

2363 So as flu season starts, we know that Black and Latino
2364 older Americans on Medicare are less likely to get vaccinated
2365 than their White counterparts. How can community pharmacists
2366 help address these disparities in vaccinations?

2367 *Dr. Pudlo. Thank you, Congresswoman, for your
2368 question. I think I will draw some comparisons to some of
2369 the conversation we have had with 3164. And, you know, while
2370 that bill isn't directly discussing vaccinations, I think you
2371 can look at how we are trying to give seniors access to
2372 testing services and treating services by pharmacists.

2373 You know, I think access alone, it is not going to

2374 reduce any kind of disparities. It comes from trust. And as
2375 you highlighted, pharmacists build that trust over decades,
2376 like your father. And, you know, that kind of relationship

2377 creates those opportunities for open dialog between a
2378 pharmacist and a patient education in those types of
2379 preventative services like vaccines.

2380 *Ms. Barragan. Well, thank you. This recently happened
2381 where my mother, who is now 85 with Alzheimer's, although she
2382 is now bed-bound, several months ago when she still could
2383 walk, walked right into the pharmacist to pick something up
2384 and they just happened to remind her of a vaccine she needed,
2385 and she was able to get it on the spot and didn't hesitate.
2386 Trying to get her to a doctor's office is a little more
2387 challenging. So this is one of the reasons that I
2388 cosponsored the Ensuring Community Access to Pharmacist
2389 Services Act, which would improve Medicare coverage of
2390 essential care provided by pharmacists, including tests for
2391 common respiratory illnesses such as strep, flu, and COVID-
2392 19.

2393 Dr. Andrews, my next question is for you. As you
2394 highlighted in your testimony, a primary care physician is
2395 your health guide over the course of your life, and that this
2396 relationship builds the trust that produces better outcomes,
2397 yet nearly a third of Americans lack access to a regular
2398 primary care provider and less than five percent of all

2399 health care spending goes to primary care.

2400 What is consolidation in the health care system, and
2401 what could more consolidation mean for patients' ability to
2402 access and afford primary care?

2403 *Dr. Andrews. Unfortunately, consolidation has been
2404 shown to increase costs versus the lower cost, high-quality
2405 care we see in independent practices.

2406 I think one of the other things that consolidation does
2407 is when you are putting profits first and patients second,
2408 then there is a push for volume over quality. So tagging it
2409 back to what you mentioned earlier, in the Patient First Act
2410 with that upfront per-member fee hybrid model, maybe I am
2411 sitting in the office talking to my Black or Latino patients
2412 and saying let's get a vaccine, and that is the most
2413 important thing I might do that day, and that is something
2414 you don't see or have the time for or the liberty to do with
2415 consolidation.

2416 *Ms. Barragan. And how does the current Medicare
2417 payment system impact doctors' ability to stay independent?

2418 *Dr. Andrews. Unfortunately, you know, going three
2419 decades without an inflation increase in payment, staff costs
2420 have increased and then the burdens of, you know, MIPS, even
2421 as well intentioned as it was, what has happened is people
2422 have to make decisions. I still want to practice medicine, I
2423 might have to shutter my doors. And then they become

2424 employed and it reduces access. Rural offices are more
2425 costly with staff and less access when they close, as well.
2426 And it all actually impacts the quality of patient care and
2427 the health of our nation.

2428 *Ms. Barragan. Well, thank you for that. That is why I
2429 cosponsored the Patients First Act.

2430 With that I yield back.

2431 *Mr. Griffith. The gentlelady yields back.

2432 *Mr. Carter of Georgia. Can I ask the gentlelady who
2433 her favorite pharmacist is? Just --

2434 [Laughter.]

2435 *Mr. Griffith. We already all know the answer. I now
2436 recognize the gentleman from Florida.

2437 *Mr. Bilirakis. Hey, Buddy, I like you, but I have got
2438 several pharmacists in my family, so I can't say that. But
2439 you are my favorite pharmacist here at this particular
2440 hearing at this particular time. Thank you very much.

2441 I appreciate you, Mr. Chairman. I appreciate the
2442 committee considering my bill, H.R. 7863, the Promoting
2443 Fairness for Medicare Providers Act, in today's hearing. I
2444 am proud to lead the bipartisan effort with my friend,
2445 Representative Ruiz, and, of course, Drs. Murphy and Davis.

2446 Today many procedures that once required a hospital
2447 visit can be performed safely and conveniently in a
2448 physician's office. I have seen it with my own eyes. But

2449 Medicare's payment system has not kept up. For procedures
2450 that require expensive medical supplies, Medicare may not
2451 reimburse physician offices enough to cover the costs of
2452 those supplies, unfortunately. That leaves doctors with a
2453 difficult choice: observe the loss or send the patient to a
2454 hospital or surgical center where the same care will cost
2455 more. For seniors that means more travel and longer waits,
2456 particularly in the rural areas. For taxpayers it means
2457 paying more than necessary. And for independent practices it
2458 is one more financial strain at a time when many are already
2459 struggling to stay open. We see that too, every day.

2460 My bill provides a straightforward, targeted solution
2461 for a narrow group of procedures involving high-cost
2462 supplies. Medicare would reimburse qualified physician
2463 offices at 90 percent of what it would pay an ambulatory
2464 surgical center. That gives physicians a fair opportunity to
2465 cover the costs of providing the care while still preserving
2466 savings for Medicare. This is a common-sense way to provide
2467 Medicare's payment system in line with how care is delivered
2468 today, all while providing more choice and lower costs to
2469 patients.

2470 But addressing this specific problem is only one part of
2471 the broader work we need to do to strengthen Medicare
2472 physician payment. I am also proud to be an original
2473 cosponsor of H.R. 9693, the Patients First Act, and I want to

2474 thank Representatives Dr. Joyce and Dr. Schrier for their
2475 leadership on this effort. It is a bipartisan effort, and I
2476 understand both doctors' caucuses endorsed this bill. The
2477 bill would provide physicians with greater stability and

2478 predictability, reduce unnecessary administrative burdens,
2479 and help protect the care that millions of seniors rely on.

2480 So Dr. Alam -- I hope I pronounced that right -- you
2481 testified that declining payments and growing administrative
2482 burdens are placing significant pressure on independent
2483 practices. Question number one for you, sir: In your view,
2484 how does that ultimately affect patients' access to care and
2485 their ability to choose their physician?

2486 You also described the concerns your students have about
2487 reimbursement uncertainty, as well, but if you could answer
2488 that question for me, elaborate, please, Doctor.

2489 *Dr. Alam. Yes. I think the main way that these
2490 effects are seen is by both delay and availability. So
2491 people can't get the care they need when they need it, and
2492 they have to travel much further to get it. I can give you
2493 an example that I saw recently.

2494 A gentleman, a farmer with a growing cancer around his
2495 eye, he had a little bit of denial, kind of really worried,
2496 maybe thought he might lose his eye. Finally, his daughter
2497 took a day off and drove literally 100 miles from southern
2498 Illinois to see me, and I was able to reassure him that it

2499 wasn't fatal, that we could save his eye, and we could do the
2500 whole procedure that day. And he was much happier. He went
2501 from being shaky and panicky to being relaxed, and was able
2502 to go back. But it would have been great for him if that
2503 care hadn't come so late and if it had come closer to home.

2504 So I think that is the fear we have, that this is a
2505 gradual erosion and care is going to get harder to find, and
2506 you will have to wait longer and longer.

2507 *Mr. Bilirakis. Yes, we don't want that, that is for
2508 sure. It is not good for our constituents or our families.

2509 What decisions are they making differently because of
2510 that uncertainty, as far as the students are concerned, the
2511 reimbursement uncertainty?

2512 And how could the Patients First Act change those
2513 calculations?

2514 *Dr. Alam. At present, most of the people who finish
2515 residency training in dermatology are going to work for large
2516 groups, hospital groups, private equity groups, because they
2517 get this guarantee of some salary for a year or two. And
2518 even though it is a difficult environment and they know they
2519 are not providing the best care for their patients and their
2520 hands are tied by all kinds of bureaucratic constraints, they
2521 have to survive. So we have to give them a fighting chance
2522 to have an independent practice.

2523 *Mr. Bilirakis. Thank you very much. I yield back, Mr.

2524 Chairman.

2525 *Mr. Griffith. The gentleman yields back. I now
2526 recognize the gentlelady from Iowa, Dr. Miller-Meeks.

2527 *Mrs. Miller-Meeks. Thank you, Mr. Chairman, and thank
2528 you to our witnesses for being here today.

2529 As a physician who has spent more than two decades
2530 caring for patients -- maybe three decades -- I have seen
2531 firsthand how important it is to have a Medicare payment
2532 system that allows doctors to focus on what matters most:
2533 providing high-quality care to patients.

2534 I have also seen how difficult it is for physicians,
2535 particularly those practicing independently, as I have, and
2536 in rural communities, as I have, to navigate a payment system
2537 that is increasingly complex, unpredictable, and disconnected
2538 from the realities of practicing medicine. Our goal should
2539 be straightforward: make sure Medicare supports access to
2540 high-quality care; reward physicians for delivering better
2541 outcomes; and provide patients with the choices they deserve.

2542 Unfortunately, the current system does not always
2543 accomplish these goals. Physicians are facing rising
2544 practice costs, workforce shortages, administrative burdens,
2545 increasing pressure to consolidate into larger health systems
2546 simply to remain financially viable while they are combating
2547 the very insurance companies and providers who deny their
2548 claims, even though they ultimately will be accepted. And

2549 this is particularly concerning in rural America.

2550 In Iowa we know that when an independent practice closes
2551 or a rural hospital is forced to reduce services, physicians
2552 -- or patients can't simply find another provider down the
2553 street. They may have to drive an hour or much further to
2554 receive care. That is why I believe we need to move toward a
2555 Medicare payment system that is predictable, transparent, and
2556 focused on outcomes. That is the goal behind the Medicare
2557 Physician Data-driven Performance Payment System Act, which I
2558 introduced with Congressman Conaway.

2559 H.R. 8622 would give us an opportunity to rethink how
2560 Medicare rewards physicians for delivering high-value care
2561 and achieving meaningful outcomes. We should be looking for
2562 ways to move beyond a simple payment for volume of services
2563 provided, and instead recognize the quality and value of care
2564 physicians deliver.

2565 But as we consider payment reform, we also need to make
2566 sure that our policies do not unintentionally disadvantage
2567 smaller practices, independent physicians, or providers
2568 serving in rural and underserved communities as was done in
2569 the Affordable Care Act in driving consolidation. A payment
2570 model that works for a large health system in an urban area
2571 may not work for a two or three-physician practice in rural
2572 Iowa. We need flexibility, reliable data, and a recognition
2573 of the very different circumstances in which physicians

2574 practice.

2575 And let me give you an example. I had recruited two
2576 ophthalmologists to Burlington, Iowa, a town of about 26,000
2577 to 36,000 individuals, and there was already an existing
2578 ophthalmologist. There are now no ophthalmologists
2579 practicing in Burlington, Iowa, a travesty. And just as we
2580 need to make sure our health care system is financially
2581 sustainable, we also need to make sure it is secure.

2582 Cyber attacks are no longer simply an information
2583 technology problem; they are a patient care problem. When
2584 hospital systems go down, physicians may lose access to
2585 medical records, pharmacies may be unable to process
2586 prescriptions, and patients may see procedures delayed or
2587 canceled. These disruptions can be particularly devastating
2588 for rural hospitals and smaller providers that lack the
2589 financial resources of a larger health system.

2590 Government has a role to play, health systems and
2591 technology companies have a role to play, and providers have
2592 a role to play. Our policies should encourage all of these
2593 stakeholders to take reasonable steps to protect sensitive
2594 patient information and ensure that health care can continue
2595 when a cyber attack occurs. Ultimately, these two issues,
2596 Medicare payment reform and cybersecurity, are about the same
2597 thing: ensuring that patients can continue to access high-
2598 quality care.

2599 Whether it is a senior in Ottumwa seeing her physician,
2600 a farmer in rural Iowa receiving care close to home, or a
2601 patient undergoing a complex procedure at a major medical
2602 center, a health care system has to be there when patients
2603 need it. We should pursue reforms that strengthen
2604 independent practices -- I see that you are nodding heads, so
2605 thank you for that -- preserve access in rural communities,
2606 reward quality and value, and protect the health care
2607 infrastructure Americans depend on.

2608 I look forward to working with my colleagues and our
2609 presenting witnesses, our physicians here who are practicing
2610 in rural areas, underserved areas, and independent practices.

2611 And thank you, Mr. Chairman. I look forward to the
2612 further discussion of today and I yield back.

2613 *Mr. Griffith. The gentlelady yields back. I now
2614 recognize Mr. Carter of Louisiana for five minutes of
2615 questioning.

2616 *Mr. Carter of Louisiana. Thank you, Mr. Chairman.

2617 Under the failed leadership of the Trump Administration
2618 we have seen the largest cuts to Medicaid in history, and ACA
2619 premiums have skyrocketed. Patients and providers are
2620 already feeling the effect of the big, ugly law. As people
2621 become uninsured, waiting room times increase, providers
2622 covered uncompensated care (sic) and facilities close. This
2623 is on top of the already severe physician shortage in the

2624 U.S. is currently experiencing (sic) and existing barriers to
2625 primary care, particularly in rural and underserved
2626 communities like those in Louisiana where 73 percent of the
2627 residents, including those throughout the river parishes in
2628 my district, live in a primary care health professional
2629 shortage area. We must take action to support providers and
2630 patients by fixing our flawed payment system and
2631 strengthening health care access before it is too late.

2632 Dr. Andrews, H.R. 9693, the Patients First Act, includes
2633 a five-year pilot program that adopts a hybrid payment
2634 structure where independent primary care providers can
2635 provide -- can receive per-month payments along the regular
2636 service fee (sic). How would this bolster the primary care
2637 workforce and lead to better health outcomes for patients?

2638 *Dr. Andrews. Thank you for that great question. It
2639 allows us to do in primary care the things that traditional
2640 fee-for-service doesn't cover, which is me going into my
2641 patient records and figuring out who is due for a mammogram,
2642 reaching out to them or having my staff reach out to them so
2643 that, instead of just ordering another mammogram, we can
2644 capture it and know that we are providing quality screening
2645 and --

2646 *Mr. Carter of Louisiana. And what will happen if
2647 Congress does not act on the fee schedule reform this year?

2648 *Dr. Andrews. You will see an even greater primary care

2649 shortage than you have today.

2650 *Mr. Carter of Louisiana. Thank you.

2651 Dr. Pudlo, pharmacists are often one of the most
2652 accessible health care providers, particularly in stress --
2653 in states like mine, where access to primary care is limited.
2654 This was especially true during COVID-19, when our
2655 independent pharmacies stepped up to play a critical role in
2656 providing testing of vaccines.

2657 For a Medicaid beneficiary who could not get an
2658 appointment with a primary care provider, how can access to
2659 pharmacists providing testing and treatment under H.R. 3164
2660 help to avoid a more expensive emergency room visit?

2661 *Dr. Pudlo. Thank you for the question, Congressman.

2662 H.R. 3164 does exactly that. Pharmacists, based on
2663 their scope of practice at the state level, has these
2664 authorities, and we have already seen that in 28 other states
2665 right now that have that authority. And we are seeing
2666 patients come to that pharmacy for those services.

2667 However, you are not seeing Medicare cover that service.
2668 We are seeing Medicaid and commercial plans do that, but not
2669 Medicare. And that is what H.R. 3164 would --

2670 *Mr. Carter of Louisiana. And very quickly for the
2671 listeners and viewers, why should Medicare recognize and
2672 cover that service for beneficiaries?

2673 *Dr. Pudlo. To me, it is a cost solution for Medicare.

2674 Right now that service is not being covered, so that
2675 individual is going to the ER for care.

2676 *Mr. Carter of Louisiana. Where that cost often times
2677 is exponentially greater in an emergency room and in curative
2678 care versus in preventive care.

2679 *Dr. Pudlo. Correct. Correct.

2680 *Mr. Carter of Louisiana. Thank you. In my remaining
2681 time I would like to speak in favor of H.R. 5121, the Dental
2682 and Optometric Care, DOC, Access Act.

2683 In Louisiana we have already recognized that abuses by
2684 vision benefit managers, VBMs, need to be addressed. This
2685 year our state legislature unanimously passed comprehensive
2686 bipartisan VBM reform to protect patients and providers from
2687 restrictive contracting practices and preserve meaningful
2688 choice. However, state action alone is not enough.

2689 Congressional action is needed to close Federal
2690 loopholes and to ensure Louisiana's protections cannot be
2691 simply sidestepped by vision plans who repeatedly avoid state
2692 provisions by asserting Federal preemption, including ERISA
2693 exemptions. H.R. 1521 would address these concerns and
2694 ensure patients and doctors have meaningful protection,
2695 regardless of how their vision plan is regulated.

2696 I am pleased to support this bipartisan effort and ask
2697 that my colleagues move forward with this common-sense step
2698 forward. We do not need to completely and continue to make

2699 health care more difficult for people to access convoluted
2700 plans so they don't understand what their coverages are and
2701 play hide the ball for the American people.

2702 I urge your continued stepping up as you have. Thank
2703 you for being here, and I urge my colleagues to follow suit.

2704 Mr. Chairman, I yield.

2705 *Mr. Griffith. The gentleman yields back. Now we will
2706 move to our waive-ons, and we are going to go to Ms.
2707 McClellan of Virginia first for her five minutes.

2708 *Ms. McClellan. Thank you, Mr. Chairman.

2709 Since passage of H.R. 1, which I call the big, ugly law,
2710 over 1,000 hospitals, clinics, and nursing homes have shut
2711 down, cut services, or at risk of doing so. These facilities
2712 are now stretched thin on the staffing and funding needed to
2713 keep their doors open, and the American people are paying the
2714 price.

2715 Expecting mothers, in particular, are having to travel
2716 farther and farther for maternity care. As of July 1 of this
2717 year, over 40 maternity wards have shuttered their doors. In
2718 Virginia, Centra Southside Community Hospital closed its
2719 labor and delivery unit in Farmville at the end of 2025,
2720 citing "reductions in Federal health care funding" among the
2721 reasons for their decision. Between 2022 and 2024, that
2722 hospital was the most common delivery hospital for women in
2723 Prince Edward County, where it is located, and the

2724 surrounding counties.

2725 Now women like Tammy James has to drive an hour away to
2726 receive care. Now, Tammy shared her story with
2727 Charlottesville Now. She was pregnant with her eighth child
2728 and near full term when she woke up in the middle of the
2729 night with a sense that something was wrong. She couldn't
2730 remember the last time she felt her baby kick, and she
2731 thought about going to the emergency room at the Farmville
2732 hospital a half hour away, but it had already closed its
2733 obstetric services just weeks earlier. So Tammy switched to
2734 Central Virginia Health Services, a non-profit health care
2735 organization in Farmville, whose services were limited, but
2736 it was close to home. But it wasn't open until the morning,
2737 so Tammy had to drive. She could either drive an hour to
2738 Lynchburg in the middle of the night, or wait until the
2739 morning to go in her home town. She waited because she
2740 already had an appointment scheduled for 8:00 a.m. in
2741 Farmville. By morning it was too late. The ultrasound
2742 showed no heartbeat.

2743 Now, reading Tammy's story, I couldn't help but think
2744 back when my placenta ruptured 9 weeks before my due date 11
2745 years ago, when I had my daughter. I most certainly would
2746 not have survived an hour-long ambulance ride to the
2747 emergency room. And for too many people, getting the care
2748 they need now means traveling farther, waiting longer, paying

2749 more, or going without it all together. And this is going to
2750 make an already bad maternal and infant mortality crisis even
2751 worse.

2752 Now, one of the bills being considered today would
2753 confront this growing trend of maternity care deserts caused
2754 by labor and delivery unit closures. H.R. 1254, the Rural
2755 Obstetrics Readiness Act, led by Representatives Kelly, Kim,
2756 Schrier, and Meuser, seeks to close maternal health gaps in
2757 rural areas by funding emergency training, equipping non-
2758 obstetric facilities, and expanding telehealth. I am a proud
2759 cosponsor of this bill which would specifically establish
2760 Federal grants for equipment, specialized training for rural
2761 staff, and pilot programs for urgent teleconsultation with a
2762 focus on areas like dedicated obstetric units.

2763 Now, while H.R. 1254 doesn't solve a systematic loss of
2764 labor and delivery units and hospital closures, it would
2765 provide real relief to communities, particularly rural ones
2766 affected by these H.R. 1-driven closures.

2767 Now, Dr. Attwood, you have said in your testimony that
2768 the maternal health crisis is a multi-factorial problem and
2769 includes sustainable payment rates as part of the solution.
2770 And while the Rural Obstetric Readiness Act doesn't touch
2771 reimbursement if a facility is trained and equipped under
2772 this bill but Medicare physician payments keep declining --
2773 as you note, they have about 33 percent since 2001 -- what is

2774 the risk to that facility's ability to sustain readiness to
2775 respond to obstetric emergencies?

2776 *Dr. Attwood. Thank you for that, and thank you for
2777 lifting up both your constituent story and your story. It
2778 highlights how important the Rural Obstetric Readiness Act
2779 truly is, and how it can truly impact the health and well-
2780 being of our patients across the country.

2781 To your point, our patients are needing care in their
2782 local communities, and we do worry that if we cannot
2783 stabilize the Medicare physician fee schedule with the
2784 importance of many of the things put forward in the Patients
2785 First Act, that more hospitals are going to close. This
2786 problem is only going to be compounded. It is not just the
2787 closure and consolidation of outpatient practices, which is
2788 an important detail both for primary care, surgical care,
2789 obstetrician gynecologists, but it will continue to close
2790 hospitals and continue to make this problem more and more
2791 difficult and ultimately more unsafe for our patients.

2792 *Ms. McClellan. Thank you, I yield back.

2793 *Mr. Griffith. The gentlelady yields back. I now
2794 recognize the gentlelady from New York, Ms. Clarke.

2795 *Ms. Clarke. Good afternoon and thank you, Chairman
2796 Griffith. And let me thank our panel of witnesses for
2797 joining us today.

2798 I want to take this time to highlight a bipartisan piece

2799 of legislation that I have led with my colleague,
2800 Representative Buddy Carter, which is H.R. 1521, the Dental
2801 and Optometric Care, or DOC, Access Act which is being
2802 considered today. This legislation seeks to lower prices and
2803 puts control back into the hands of patients and their
2804 doctors.

2805 For far too long our nation's health care system has
2806 increasingly grown out of reach for Americans across the
2807 country. Specifically, doctors and patients have been
2808 sounding the alarm about the practices of vision benefit
2809 managers, or VBMs. VBMs have engaged in rampant
2810 consolidation, vertical integration, which has led to rising
2811 costs, less transparency, and patients to have less control
2812 in deciding their care -- the care they receive. These
2813 practices have resulted in companies having a monopoly in the
2814 vision market, so the same company that administers a
2815 patient's vision benefit can operate retail locations and be
2816 affiliated with filling prescriptions and manufacturing
2817 eyewear.

2818 It is clear patients deserve lower costs, greater
2819 transparency, accountability, and the freedom to choose their
2820 care, which is why we have introduced bipartisan legislation,
2821 a common-sense step toward addressing anti-competitive
2822 conduct and strengthening protections for patients.

2823 Additionally, I want to take this opportunity to

2824 highlight another piece of legislation that would ensure the
2825 stability in Medicare provider payments and protect the
2826 patients -- the care patients receive.

2827 I am proud to lead H.R. 2199, the Restore Protections
2828 for Dialysis Patients Act, alongside my colleagues,
2829 Representative Mike Kelly, Neal Dunn, Danny Davis, John
2830 Joyce, and Raul Ruiz, which would restore longstanding
2831 protections, preserve patient choice, and safeguard Medicare
2832 dollars. This bill is supported by most members in this
2833 committee, some of whom are here today.

2834 Kidney disease is an urgent health equity crisis in our
2835 country. In my state of New York, tens of thousands depend
2836 on life-sustaining dialysis every week. And nationally,
2837 Black Americans are nearly four times more likely to develop
2838 kidney disease. For more than 40 years people with kidney
2839 failure have been able to stay on their employer's health
2840 plans for 30 months. Now third-party administrators are
2841 excluding dialysis coverage, forcing patients off their plans
2842 and disrupting access to dialysis, transplant evaluations,
2843 and other critical care.

2844 I want to urge my colleagues to join me in moving this
2845 impactful and lifesaving bill forward, and I want to thank
2846 all of our experts who are here today for lending your
2847 expertise as we move forward in our quest to bring our
2848 medical infrastructure into the 21st century.

2849 With that, Mr. Chairman, I yield back.

2850 *Mr. Griffith. The gentlelady yields back. I now
2851 recognize the gentleman from New York, Mr. Tonko.

2852 *Mr. Tonko. Thank you, Chair, and I thank the Chair

2853 Griffith and Ranking Member DeGette for hosting this
2854 important hearing today examining legislative proposals to
2855 help strengthen physician payments and preserve patients'
2856 continued access to care. And thank you to all of our
2857 witnesses for being here and sharing advice and expertise.

2858 I would like to use this moment to briefly highlight a
2859 piece of legislation that I have co-authored that is the
2860 Radiation Oncology Case Rate Value-Based Payment -- Program
2861 Act. This bill would set fair bundled Medicare payments for
2862 cancer radiation therapy to improve patient care and health
2863 outcomes. And while we are not considering the ROCR Value-
2864 Based Payment Act today, I would encourage the committee to
2865 support this bipartisan bill. It would provide payment
2866 stability and help offset the cost of future physician
2867 payment reforms, including the Patients First Act which we
2868 are discussing today.

2869 That being said, I am thrilled to see the inclusion of
2870 my bill, the Alzheimer's Screening and Prevention Act, or
2871 ASAP, which would create a pathway for Medicare coverage of
2872 FDA-approved blood biomarker screening tests.

2873 Over the years I have gotten to know many people in our

2874 community that are living with the disease, and have seen the
2875 heavy burden it places on them and certainly their families.
2876 Take, for instance, my constituent, Erin Vickers, who is a
2877 caregiver to her mother who has Alzheimer's. She shared that
2878 it took months to get an appointment with a neurologist and
2879 then several more months to get a diagnosis. To Erin, the
2880 inability to receive an early diagnosis was like a death
2881 sentence for her beloved mother.

2882 So Dr. Rebecca Andrews, as you know, more than seven
2883 million Americans have Alzheimer's. It is the most common
2884 form of dementia. And unfortunately, one in three seniors
2885 dies with Alzheimer's or another dementia. As the immediate
2886 past chair of the Board of Regents for the American College
2887 of Physicians, can you speak, please, to some of the
2888 challenges that physicians face in diagnosing and managing
2889 Alzheimer's?

2890 *Dr. Andrews. Yes, and thank you for your question.

2891 I think we have covered how much access is limited for
2892 patients and why the Patients First Act is so important for
2893 stabilizing treatment.

2894 In addition, some of the things that it has in there,
2895 including this five-year hybrid payment, would allow for
2896 certain things like a conversation between myself and your
2897 constituent trying to plan for the future for her mother,
2898 advising her what the test for Alzheimer's would look like --

2899 because it is not a clear yes-or-no, it comes out as a
2900 probability and that takes time to discuss. And then it
2901 allows for the important planning, such as any chronic
2902 condition. What do we need to do to get your life set up,
2903 your mom's life set up so that you can appropriately care for
2904 her?

2905 And as we have said many times today, in the lower-cost
2906 environments that provide a high quality of care for you --
2907 and this is just one disease and one example, but it is a
2908 growing problem that you highlight.

2909 *Mr. Tonko. Thank you so much.

2910 And with a tool like a blood-based biomarker test, is it
2911 going to assist, do you believe, in earlier, more accessible
2912 diagnoses?

2913 *Dr. Andrews. Clinically, I can tell you that when
2914 people come in to the office worried about memory, their
2915 first question isn't just to mention in general, it is about
2916 Alzheimer's. And everyone is looking for a way to be able to
2917 diagnose it sooner so that they can appropriately plan, enjoy
2918 the remaining time with their memory, and have time with
2919 their family.

2920 I certainly do think earlier diagnoses of all conditions
2921 allows for better care and better planning. And with the new
2922 treatments that are on the horizon, early diagnosis is
2923 important.

2924 *Mr. Tonko. Thank you so much.

2925 Well, in closing, the bipartisan ASAP Act expands access
2926 to early detection and gives individuals and their families
2927 more time to plan, to start treatment, and seek support when
2928 it matters most. And my hope is that we can get this
2929 legislation across the finish line ASAP.

2930 So I thank you and yield back. Thank you, Mr. Chair.

2931 *Mr. Griffith. The gentleman yields back ASAP.

2932 [Laughter.]

2933 *Mr. Griffith. And now we will move forward.

2934 I ask unanimous consent to insert in the record
2935 documents included in the staff hearing documents list.

2936 Without objection, so ordered.

2937 [The information follows:]

2938

2939 *****COMMITTEE INSERT*****

2940

2941 *Mr. Griffith. I would like to thank all of our
2942 witnesses again for being here today. We had bonus
2943 questioners in our waive-ons, which we always appreciate.

2944 After today members may have additional written
2945 questions for you all. I will remind members they have 10
2946 business days to submit questions for the record, and I ask
2947 the witnesses to respond to the questions promptly. Members
2948 should submit their questions by the close of business on
2949 Tuesday, September 29.

2950 Without objection, the subcommittee is adjourned.

2951 [Whereupon, at 1:06 p.m., the subcommittee was
2952 adjourned.]