Statement
of the
American College of Physicians (ACP)

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Subcommittee on Health

"Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity"

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Chairmen Guthrie and Griffith, Ranking Members Pallone and DeGette, and the distinguished members of the subcommittee, thank you for the invitation to testify today.

My name is Dr. Rebecca Andrews. I am an internal medicine physician and the Immediate Past Chair of the Board of Regents of the American College of Physicians (ACP), which represents more than 163,000 internal medicine physicians — nearly half of the nation's primary care physicians, along with those in hospital medicine and internal medicine subspecialties.

Primary care is the foundation of every high-functioning health system. A primary care physician is your health guide over the course of your life, and that longitudinal relationship builds the trust that produces better outcomes. Yet U.S. health outcomes trail other developed nations.

Two years into practice, I had tangible evidence of the power of primary care. A 29-year-old woman called, concerned about a breast lump. She became patient number 26 that day. I have now cared for her for 20 years - through breast cancer, its return, and her remission. It took me ten years to convince her to treat her depression, which let her return to work. I have controlled her diabetes for five years. Two weeks ago, after years of discussion, she finally agreed to a medication to protect against heart disease.

This is primary care: comprehensive care that is undervalued, trust built over years that produces better health outcomes. Ten additional primary care physicians per 100,000 people adds two years of life expectancy; adding access to ten primary care physicians means that your constituents will live twice as long compared to increasing access to any other types of doctors. And yet, we are losing this exact practice area.

As a practicing primary care internal medicine physician, Director of Ambulatory Education for the Internal Medicine Residency Program, and Director of the Primary Care Residency Education Program at the University of Connecticut, I have seen firsthand the declining number of medical students choosing primary care. While many factors have contributed to this decline, decades of undervaluing time-intensive services, including primary care, in the Medicare Physician Fee Schedule (PFS) have contributed to the persistent challenges facing the primary care workforce. Historically, the PFS has paid physicians more for medical procedural services than for the cognitive, longitudinal, and preventive care central to primary care. This has directly translated to lower pay for primary care physicians – who provide time-intensive, relationship-building care – creating a significant physician income gap, where primary care compensation sits closer to the bottom of the physician pay table when compared to subspecialists.

Medical students and residents, many of whom take out substantial student loans averaging $223,130 to pay for their medical education, are choosing specialties other than primary care because of low primary care pay and earning potential relative to other specialties. I see these pressures firsthand in my own residency program. Of approximately 60 internal medicine residents who graduated last year, only six chose to practice primary care. Many residents enter training interested in primary care, but I have watched that interest shift as the financial realities of repaying student loans, saving for retirement, and supporting a family become increasingly apparent. The overwhelming majority ultimately pursue hospital medicine or subspecialty training instead.

Despite recent efforts by the Centers for Medicare and Medicaid Services (CMS) to increase primary care compensation through the PFS, compensation still lags significantly behind procedural specialties. Because Medicare payment policies influence payment across the health care system, including for private payers, the PFS' historical undervaluation of primary care has implications well beyond Medicare. Medical students and residents, many of whom take on substantial student loan debt to finance their medical education, must weigh that debt against the significantly lower earning potential of primary care relative to many other specialties.

A robust primary care physician workforce has been shown time and time again to be essential to improving patient outcomes and population health while reducing health care costs. Payment policies must recognize the value of primary care and support a robust, sustainable primary care and physician workforce. As Congress considers bipartisan legislation to improve Medicare's outdated payment structure, ACP supports the following legislation slated for discussion in today's hearing that would enhance value-based care, improve patient outcomes, reflect transparent and fairer compensation for physicians, and protect patients' personal health information.

Support for the Patients First Act of 2026, H.R. 9693

ACP strongly supports the Patients First Act, which would provide comprehensive Medicare payment reform while also investing in primary care. We commend Drs. Joyce, Murphy and Schrier for their leadership and commitment to advancing this critical legislation. The bill would address longstanding issues that have caused significant payment instability for

physicians, including the lack of consistent inflationary updates, outdated practice expense data, and the effects of budget neutrality. It would also maintain existing Advanced Alternative Payment Model (APM) participation thresholds for three years, providing greater stability for physicians participating in value-based care and further supporting Medicare's transition away from a fee-for-service model.

The College recently submitted comprehensive comments to a request for information (RFI) on this legislation to strengthen the legislation's impact on internal medicine physicians and our patients. Below, we highlight several key recommendations in brief.

Title I – Strengthening Reimbursement and Patient Access

Sec.101 would provide a much-needed permanent inflationary update to the PFS by creating a new formula tied to the Medicare Economic Index (MEI) minus 1 percentage point. **While we understand this provision will be a significant investment, there are potential offsets that can be explored, such as appropriately designed site-neutral reforms that generate savings while protecting rural, safety-net, and other facilities where payment changes could threaten patient access. Savings should not come from further across-the-board PFS reductions, reductions in primary care payment, or policies that shift costs to patients or physician practices.**

Sec.102 would establish a five-year hybrid payment pilot program to pay independent primary care practices a per-member-per-month fee alongside traditional fee-for-service billing. If implemented, the five-year demonstration would provide qualifying independent primary care practices with monthly payments for designated primary care services, including care management, behavioral health integration, office-based visits, and communications with patients and caregivers. The model would provide more predictable resources for comprehensive, longitudinal care. This approach would better recognize the substantial work primary care physicians provide outside of traditional face-to-face visits and give practices more reliable resources to support comprehensive patient care. It would also operate outside of the PFS budget neutrality and would waive patient cost-sharing.

The College supports the legislation's intent to help independent practices remain viable by disallowing participation by majority-owned private equity, insurance, and other corporate entities from participating in the hybrid payment model pilot. **However, we urge that the legislation be modified to ensure it does not preclude physicians in accountable care organizations (ACOs), or those physicians serving patients in the community but employed by primary care clinics or rural health clinics serving the public, from participating in the pilot.**

Sec.103 would require CMS to extend the 1.00 geographic practice cost index floor and provide additional adjustment during high-inflation years. These recommendations are also consistent with ACP's *Improving Health and Health Care in Rural Communities* position paper. These policies would help to protect access in rural and lower-cost areas, where physician practices are also experiencing increases in staffing and operating costs.

Congress should direct the Secretary to monitor whether the adjustments adequately reflect practice costs and protect beneficiary access.

Title II - POINTS (Patient Outcome Improvement National Tabulation System)

Sec. 101-103 would transition Medicare's Merit-based Incentive Payment System (MIPS) to POINTS. We particularly appreciate the proposed creation of a clinician-led Quality Reform Task Force with significant representation from professional medical organizations and health care professionals to help develop and select measures that are meaningful to physicians and patients while reducing unnecessary reporting burden. The College supports policies that provide physicians with greater flexibility to report on meaningful quality metrics and participate in payment models that best suit their practices' unique needs. This would allow clinicians to select measures most appropriate for their practices and patients, reduce participation burden, and provide clinicians with more time to focus on patient-centered care.

ACP recommends that the POINTS program ensure that quality and care-efficiency measures are evidence-based, clinically meaningful, appropriately risk-adjusted, and limited to outcomes that physicians and practices can reasonably influence. Given that these categories would account for 80 percent of the total POINTS score, there must be safeguards against penalizing physicians for patient complexity, social risk, inadequate sample size, or care delivered outside their control. Awarding higher scores for reporting new or substantively changed measures without an established benchmark creates an incentive to report measures even when sufficient data are not yet available to establish a meaningful benchmark, and can establish benchmarks for future performance. **We request clarification on whether POINTS will retain the existing MIPS benchmark methodology and on what constitutes a substantive measure of change.**

Title III – APM Improvement

Sec 302 would support requiring notice-and-comment rulemaking for mandatory CMS Innovation Center models and certain decisions affecting the expansion or early termination of Innovation Center models. **We urge Congress to direct the Department of Health and Human Services (HHS) Secretary to provide adequate advance notice and avoid material changes to payment, benchmarking, attribution, quality, or risk requirements during a performance period.**

While we support greater public reporting, savings alone are not a sufficient measure of a model's success. **Congress should require HHS to issue reports that explain the savings methodology and account for incentive payments, infrastructure investments, and administrative costs. Reports should also assess quality, beneficiary access, patient experience, health equity, physician participation and retention, administrative burden, and effects on practice consolidation.** A model should not be considered successful solely because it lowers Medicare spending if it also restricts access, worsens outcomes, increases physician burden, or makes participation impractical for independent practices.

Title IV – Physician Payment Improvements

Sec.401 would raise the budget neutrality threshold from $20 million to $57.64 million and would update the threshold every five years thereafter based on cumulative increases in the MEI. However, this provision would mitigate, but not resolve, the structural problem of financing improvements to physician payment by reducing other physician services. **We urge Congress to monitor whether the change reduces the frequency and magnitude of budget neutrality adjustments. Additional investment in primary care and other high-value services needs to be financed outside the PFS rather than through further reductions to physician payment.**

Sec. 402 would require CMS, in specified circumstances, to revise spending estimates and budget neutrality adjustments for newly unbundled codes based on actual utilization. This requirement would apply when expenditures for a newly unbundled code exceed 0.1% of total estimated PFS expenditures. A transparent and symmetrical reconciliation process would improve conversion factor accuracy and prevent permanent payment reductions based on utilization that did not occur. **Congress should direct the Secretary to publish the data, assumptions, and methodology used to calculate each reconciliation adjustment and to use sufficiently complete claims data before correcting. In implementing this provision, CMS should consult affected specialty societies to identify changes in coding, coverage, clinical practice, or claims processing that may explain differences between projected and actual utilization.**

Sec.403 would require CMS to update the direct costs associated with clinical labor, equipment, and medical supplies at least once every five years. Outdated data can substantially distort payment and particularly disadvantage office-based practices that directly bear these costs. **Congress should direct CMS to establish a transparent process that includes specialty societies, practicing physicians, and representatives of small, rural, and independent practices.** CMS should publish its data sources and methodology and recognize differences in purchasing power, staffing arrangements, and costs across practice settings. National averages based disproportionately on large organizations could understate the costs incurred by smaller practices. CMS should model the effects of proposed updates by specialty, service, geography, site of service, and practice type. **Congress should authorize the Secretary to establish appropriate transitions when simultaneous updates would cause abrupt reductions that threaten access to care or the viability of medical practices.** Updating direct inputs should also complement continued improvements to the data and methodology for indirect expenses, including rent, health information technology, billing, administrative staff, and regulatory compliance.

Sec. 404 would limit year-to-year conversion factor variance to no greater than 2.5 percent (decrease or increase) each year, helping to prevent unpredictable changes resulting from budget neutrality adjustments. **Congress should clarify how CMS must treat any adjustment exceeding the limit.** If the underlying budget neutrality requirement remains in effect, an unapplied adjustment could otherwise be deferred or accumulated, producing a larger reduction in a later year. **The provision should reduce volatility rather than postpone it.** The limit also should not prevent or delay policies

that improve access or appropriately value primary care, telehealth, care management, behavioral health integration, or other high-value services. **When a beneficial policy would cause the adjustment to exceed the limit, Congress should consider an exemption from budget neutrality or funding outside the PFS**.

Support for the Provider Reimbursement Stability Act of 2026, H.R. 8163

ACP has long championed the policies in the Provider Reimbursement Stability Act of 2026, H.R. 8163, sponsored by Dr. Murphy and Rep. Schneider. This legislation would strengthen and stabilize the Medicare payment system by reducing annual fee schedule payment cuts driven by budget neutrality constraints. It would raise the threshold for enacting budget neutrality cuts and use cumulative increases in the MEI to update the threshold every five years thereafter. It would also update the direct costs associated with practice expenses (clinical labor, equipment prices, and medical supply prices) at least once every five years. Additionally, it would limit the year-to-year conversion factor variance to no greater than 2.5 percent (decrease or increase) each year. The College is pleased that these provisions are included in the Patients First Act.

Support for the Medicare Physician Data-Driven Performance Payment System Act, H.R. 8622

This legislation represents a practical, bipartisan step toward broader Medicare payment reform that ACP has long championed. For nearly a decade, MIPS has disproportionately penalized small and rural practices by imposing steep, zero-sum penalties on physicians without meaningfully improving patient care and outcomes. ACP supports H.R. 8622, sponsored by Drs. Miller Meeks and Conaway, which would replace MIPS with the Data-Driven Performance Payment System to provide physicians with the stability and predictability they need to invest in meaningful quality improvement. We support the bill's central reforms, including reducing excessive penalties; reinvesting funds into quality improvement and support for under-resourced practices; implementing quarterly performance feedback to help physicians make real-time improvements; enhancing transparency in cost attribution to support better clinical decision-making; and protecting physicians from penalties when sufficient performance data is not provided.

Support for Rural Obstetrics Readiness Act, H.R. 1254

ACP recognizes the importance of addressing our nation’s maternal mortality crisis through policies to ensure that pregnant and postpartum people have access to critical resources, health care coverage, community-based and social supports, and the high-quality health care they need – no matter where they live. H.R. 1254, sponsored by Rep. Kelly, would fund emergency obstetric training for rural health care facilities without dedicated labor and delivery units. It would also provide grants for necessary equipment and establish telehealth consultation networks, allowing physicians in rural communities to access real-time specialist guidance for high-acuity events. We urge the Subcommittee to mark up this critical legislation to help close the rural maternal care gap and improve maternal health outcomes nationwide.

Recommendations for the Health Care Cybersecurity and Resiliency Act of 2026 (draft legislation)

ACP commends the Subcommittee for examining policy solutions to address the increased prevalence of cybersecurity attacks in health care. Cybersecurity incidents over the past several

years have significantly impacted patient data privacy and physician cash flows, limiting their ability to care for patients. These cyberattacks are especially damaging to physicians in smaller practices that serve rural and underserved communities.

The draft legislation aligns with ACP's policy position to bolster the U.S. health care cybersecurity infrastructure and protect personal health information (PHI) from malicious actors. However, gaps remain that could be strengthened to better support physicians.

> **Sec. 8** would direct HHS to update the Health Insurance Portability and Accountability Act's Security Rule to require minimum risk-based cybersecurity practices, such as multifactor authentication, encryption of PHI, and monitoring/penetration testing. These best practices are based on the National Institute of Standards and Technology frameworks and the Health Sector Coordinating Council and Cybersecurity and Infrastructure Security Agency's performance goals. We note that these standards are designed for large health systems with dedicated IT and cybersecurity staff. They are not scaled for small, independent practices. **We urge Congress to ensure flexibility for independent physician practices by establishing a tiered or scaled standard under Section 8 for small and independent practices, consistent with their size, resources, and risk profile.**
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> **Sec. 10** would provide grants to qualifying entities for the adoption and implementation of cybersecurity best practices. **While we agree with the intent of this section, we urge Congress to expand grant eligibility to include independent physician practices, particularly small and rural practices.**

Conclusion

On behalf of ACP, I thank the Subcommittee for holding this critical legislative hearing. The bills underscored in this statement represent a meaningful step towards a Medicare payment system that is stable, fair, and sustainable for physicians and patients alike, while also strengthening the resilience of our nation's health care infrastructure. We thank you for the opportunity to testify today and stand ready to work with the Energy and Commerce Committee to advance these meaningful bipartisan solutions. Thank you.