August 21, 2026

The Honorable John Joyce, M.D.
Co-Chair, GOP Doctors Caucus
U.S. House of Representatives
Washington, DC 20515

The Honorable Kim Shrier, M.D.
Chair, Democratic Doctors Caucus
U.S. House of Representatives
Washington, DC 20515

The Honorable Greg Murphy, M.D.
Co-Chair, GOP Doctors Caucus
U.S. House of Representatives
Washington, DC 20515

RE: Medicare Physician Payment System Request for Information

Dear Representative Joyce, Representative Shrier, and Representative Murphy,

United States of Care (USofCare) is pleased to submit comments in response to the GOP and Democratic Doctors Caucuses' request for information on strengthening the Medicare physician payment system, and more specifically, H.R. 9693, the *Patients First Act*.

USofCare is a nonpartisan, nonprofit organization working to ensure that everyone has access to quality, affordable health care regardless of health status, social need, or income. Importantly, we are committed to improving the health of everyday people and are eager to engage in solutions that do just that. We advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in the states and listening to people's experiences with the health care system, we are able to identify unique insights from patients on the ground to amplify for uptake at the federal level.

Patients First Act

Hybrid Payment Model for Primary Care Services

Public opinion research conducted by USofCare in 2025 illuminated public perceptions and priorities regarding primary care and patient experiences. This research concluded that people value having a regular primary care clinician. **More than eight out of 10 (83%) respondents said they highly prioritize having a regular primary care clinician**; more than half (52%) say it's a top priority. However, cost and access are the most cited barriers to accessing primary care across all demographics. Additionally, this research demonstrated that

primary care is being underutilized to address chronic disease in the U.S. Among adults who have recently received primary care, **only 27% used it to manage a chronic condition**.

Primary care is the foundation of a high-performing health care system that addresses people's health care needs. The evidence is clear that primary care is associated with better health outcomes, lower costs, and greater health equity. Moreover, across demographics, people have a clear vision that primary care in the U.S. should be affordable, accessible, and convenient. However, the current health care system - and how it values primary care - does not realize that vision. As a result, patients are left with an inadequate or poor experience that fails to meet their primary care needs, or worse, unmanaged chronic conditions and lower life expectancy.

Despite these benefits, less than five percent of all health care spending goes to primary care, and that number is declining. Nearly one-third of people nationwide don't have access to a regular primary care provider. People's access challenges – and related workforce shortages – are particularly acute in rural communities and other underserved areas, leading many to seek care in more costly emergency settings or forego care altogether. Low levels of investment also disproportionately affect people with chronic conditions who rely on consistent, coordinated primary care services to manage their health needs and avoid hospitalizations.

These realities are a symptom of the fundamentally flawed Medicare Physician Fee Schedule (PFS), which chronically undervalues primary care. As currently structured, the Medicare PFS overvalues episodic care and procedures in an increasingly fragmented, difficult to navigate sick-care environment. This comes at the expense of relationship-based, whole-person preventive and primary care designed to keep people healthy.

Additionally, primary care underinvestment can lead to an overutilization of low-value, high-cost services that do little to improve health outcomes and create financial instability for practices that rely on health care volume rather than improved health outcomes to keep their doors open. As a result, the number of independent physician practices across the U.S. is declining, in part due to the current system forcing physicians to consolidate with larger, corporate entities just to keep their practices afloat. In fact, the fee-for-service system is often cited as a major driver of these trends, none of which benefits primary care providers and the patients they serve.

The Hybrid Payment Model for Primary Care Services included in the *Patients First Act* represents an important step towards addressing the undervaluation and providing primary care providers with the necessary support for delivering high-quality, coordinated, whole-person care. Hybrid payment models for primary care have not only demonstrated improvements to quality of care for patients and long-term cost savings, but they also give providers a consistent stream of upfront payments. A 2021 National Academies of Science, Engineering, and Medicine (NASEM) report identified a need for hybrid models in primary care that include prospective payments for integrated team-based care, adjusted for medical and social complexity, to better deliver care. **USofCare strongly supports the inclusion of the Hybrid Payment Model for Primary Care Services and urges the bill sponsors to maintain this model in the legislation.**

Nonapplication of Cost Sharing for the Hybrid Payment Model for Primary Care Services

By establishing a relationship with a primary care provider, patients are able to assume a greater role in their health care alongside physicians, nurses, and others that make up their care team. Despite this and other benefits associated with regular primary care access, however, an

increasing number of Americans are going without a regular source of primary care. Health care costs – even as low as $1 to $5 – have continued to be shown to be significant barriers to care for patients, especially for low-income people. USofCare's own listening research found that cost concerns do lead to people not seeking out primary care services – particularly among rural residents. While 93% of rural adults were satisfied with their insurance coverage of primary care, they are significantly more likely (32%) than urban (21%) and suburban (24%) adults to report not seeking out primary care because they are unable to afford it. **USofCare strongly supports the nonapplication of beneficiary cost sharing in the Hybrid Payment Model for Primary Care Services.**

"Excluded Practice" Definition for the Hybrid Payment Model for Primary Care Services

The *Patients First Act* includes a definition of "excluded practice" for the purposes of determining provider eligibility for the Hybrid Payment Model for Primary Care Services that aims to target eligibility for this model to independent physician practices. We appreciate that this model will be costly and that bill sponsors needed to establish eligibility criteria consistent with the resources available to fund this model. Given the limited resources we also appreciate the targeted focus on independent physician practices given USofCare's long-standing concern with consolidation and vertical integration.

However, we encourage the bill sponsors to consider changes to the bill's eligibility criteria that would allow for participation of federally-qualified community health centers (FQHCs) in the Hybrid Payment Model for Primary Care Services. FQHCs are critical – and, sometimes, the only – sources of primary care in their communities, particularly in rural areas. FQHCs deliver quality, whole-person care while supporting care coordination across the spectrum of patients' physical and mental health care needs – which is especially important for high-needs populations. Medicare pays FQHCs under a prospective payment system on a per-visit basis with geographic adjustments; however, FQHCs – and the patients they serve – would benefit greatly from the hybrid payment model included in this legislation. We appreciate the goal of supporting and preserving Medicare beneficiary access to independent physician practices, but believe that bolstering FQHCs – which, on average, had net margins of -2.1% in 2024 – is equally important.

Quality Reform Task Force

Membership

The *Patients First Act* establishes the Quality Reform Task Force for the purposes of issuing recommendations to the Secretary on the use of quality, resource use, and care efficiency measures as part of the Patient Outcome Improvement National Tabulation System (POINTS), which will replace the current Merit-Based Incentive Program (MIPS). **Given the impact that clinician quality programs have on the quality of care that Medicare beneficiaries receive, USofCare urges the bill sponsors to include an explicit requirement that the Secretary include beneficiary representation on the Quality Reform Task Force.** While beneficiaries may not have the coding or billing expertise of other members, they do represent the downstream effects of changes made related to physician payment and are uniquely positioned to speak to impacts on health care access in ways that physicians themselves cannot.

Unfortunately, existing quality measures may have little connection to the patient experience. We believe there should be a focus on adopting a core set of patient-reported

quality measures that center both patient-reported outcomes and patient-reported experiences to fully capture the patient's perspective. The inclusion of beneficiary representatives on the Task Force can help facilitate the advancement of this goal and, importantly, help ensure that reforms to quality programs are truly reflective of a "patients-first" approach.

CMS Innovation Center Model Requirements

New Notice and Comment Rulemaking Requirement for the Termination of a CMS Innovation Center Model

The CMS Innovation Center's authorizing statute requires the termination or modification of a model if it fails to meet one of three tests: (i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable subchapter; (ii) reduce spending under the applicable subchapter without reducing the quality of care; or (iii) improve the quality of care and reduce spending. The *Patients First Act* would only allow the Secretary to terminate a model pursuant to notice and comment rulemaking.

We appreciate the establishment of a uniform process for model terminations that allow ample notice, explanation of the reasons for the termination, and opportunity for public comment; however, **USofCare urges the bill sponsors to amend this section to make it clear that CMS has flexibility around this requirement if CMS determines that a model is reducing the quality of care beneficiaries are receiving and/or causing beneficiary harm.** As you are aware, the notice and comment rulemaking process can be lengthy, and we believe it is important to ensure that CMS has the flexibility it needs to pause or terminate models if beneficiaries are being negatively impacted.

APM Conversion Factor

Our years of listening work has shown that people desire the high-quality care that can be achieved through what we call "patient first care" (a.k.a. value-based care) that prioritizes personalized, high-quality, coordinated health care, focusing on the needs of the individual person with the goal of enhancing both the experience and health outcomes for the patient. Given this, we believe that Congress should promote and incentivize provider participation in advanced alternative payment models (APMs), which have demonstrated success in improving health outcomes and reducing costs. **USofCare supports a provision in the *Patients First Act* that applies a higher conversion factor for Qualifying Participants in advanced APMs.**

Offsets and Fiscal Responsibility

We appreciate the Doctors Caucuses' request for feedback on potential offsets for Medicare physician payment reform legislation. Recognizing that meaningful reforms will be costly and offsets will likely need to come from a range of different policies, we strongly urge Congress not to consider any policies that would reduce benefits or increase costs for Medicare beneficiaries. Reforming the manner in which Medicare pays physicians and other clinicians to ensure accuracy and appropriateness helps support the care delivery system – but it should not come at the expense of Medicare beneficiaries.

USofCare believes there are a range of policies that not only generate the savings necessary to cover the cost of Medicare physician payment reform, but also help improve affordability for Medicare beneficiaries and strengthen the Medicare program more broadly. While Medicare beneficiaries' overall satisfaction with the program is high, people with Medicare still face affordability challenges. A recent poll from USofCare found that all people – including those with Medicare – perceive a health care system that is unaffordable and those perceptions are rooted in the realities of their experiences with high health care costs. Of the respondents with Medicare coverage, 76 percent believe that health care costs are unaffordable for people and families. Additionally, 42 percent reported at least one financial pressure (i.e. contacted by a credit agency, took out a loan, etc.) related to a medical bill in the last two years and 20 percent said they have a medical bill that is past due that they are unable to pay.

Equalizing Certain Payments Across Sites of Service

A **major driver of high costs** in hospital care – and the health system as a whole – stems from **payment differentials between care settings**. Under their respective payment systems, Medicare pays outpatient health facilities, including hospital outpatient departments (HOPDs) higher rates than physician offices for delivery of the same service. This discrepancy incentivizes hospitals to move patients into higher-cost settings in order to receive a higher payment rate. The payment rate under the OPPS is often 200-300% of the rate paid for the same services in physician offices – shifting additional costs onto beneficiaries and the Medicare program as a whole.

Hospital and health system acquisition of physician offices and outpatient facilities has highlighted the need to implement site neutral payments in Medicare and also in the commercial market. In too many instances consumers are charged more for a service on the sole basis of where it's performed, **increasing costs to them personally as well as to the system overall.** What's more, there's **no improvement in the quality** of that service.

The Centers for Medicare & Medicaid Services (CMS) took action in the Calendar Year (CY) 2026 Hospital Outpatient Prospective Payment final rule to establish a site-neutral payment rate for drug administration services. This change alone is estimated to save Medicare beneficiaries $70 million in reduced coinsurance costs and the Medicare program $210 million for CY 2026 alone. In the CY 2027 Hospital Outpatient Prospective Payment proposed rule, CMS is proposing to extend this policy to imaging without contrast services, which would reduce beneficiary premiums and cost sharing by $140 million and generate $190 million in savings to the Medicare program in the first year alone.

There is evidence indicating that billing for a number of different services has shifted from the PFS to the OPPS, resulting in increases in utilization of higher-cost settings. Similarly, the Medicare Payment Advisory Committee (MedPAC) has also signaled the misalignment in payment rates when it comes to charges for care across dozens of services delivered at off-site locations. **We strongly urge Congress to build on regulatory efforts from CMS and apply site neutral payment rates to additional services that can be safely performed in outpatient settings with a particular consideration of the 66 services identified by MedPAC.**

Medicare Advantage Reforms

Enrollment in Medicare Advantage (MA) has grown significantly over recent years – and now more than half of beneficiaries are enrolled in the program. As enrollment in the MA program

continues to eclipse Traditional Medicare, this increased enrollment is driving additional Medicare spending in MA, creating a more urgent need to ensure that spending is appropriate and that the program is operating in a manner consistent with beneficiaries' needs. Over the next decade, MA alone will account for more than $9 trillion in Medicare expenditures.

When Congress created the MA program, the stated purpose was to save Medicare money through a managed care delivery model; however, that intent has not borne out. According to MedPAC – and reaffirmed through additional analysis – MA payments are currently $76 billion above what spending would have been if MA enrollees were in Traditional Medicare for 2026. MedPAC primarily attributes these overpayments to upcoding in MA relative to Fee-for-Service and favorable selection of beneficiaries into MA.

Because Medicare Part B premiums are calculated on the basis of projected expenditures, **Overpayments and higher spending in MA increase Medicare Part B premiums for all beneficiaries.** In fact, a 2026 analysis by the Joint Economic Committee estimates that MA overpayments increased Part B premiums by $212 per enrollee in 2025, totaling $13.4 billion in higher premiums. Overpayments in MA also reduce the solvency of the Medicare Hospital Insurance Trust Fund, which is projected to be depleted in 2033.

Additionally, **studies and surveys of Medicare beneficiaries have found similar rates of satisfaction, access to care, and care coordination among those with MA and Traditional Medicare, further calling into question the value of those additional payments for MA enrollees.** As a result, it is important for Congress to examine the program for opportunities for improvement. **USofCare urges Congress to consider MA policy reforms for other potential offsets for Medicare physician payment reform.**

Conclusion

Thank you for your leadership in efforts to reform the Medicare physician payment system, and for the opportunity to respond to this RFI, which builds towards USofCare's mission to ensure that everyone has high-quality, affordable, personalizable, and understandable access to care. Please reach out to Alyssa Penna, Director of Federal Policy, at apenna@usofcare.org, with any questions.

Sincerely,

Lisa Hunter (she/her)
Senior Director for Policy & External Affairs
United States of Care