AMERICA'S PHYSICIAN GROUPS

August 20, 2026

The Honorable Greg Murphy
Co-Chair, GOP Doctor's Caucus
407 Cannon House Office Building
Washington, DC 20515

The Honorable John Joyce
Co-Chair, GOP Doctor's Caucus
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier
Chair, Democratic Doctor's Caucus
1110 Longworth House Office Building
Washington, DC 20515

Submitted via amy.zhou@mail.house.gov and catherine.hayes@mail.house.gov

Re: Patients First Act

Dear Doctors Murphy, Joyce, and Schrier:

America's Physician Groups (APG) appreciates the opportunity to respond to the Republican and Democratic Doctors Caucuses' Request for Information (RFI) on the Patients First Act of 2026 (H.R. 9693), which would reform physician payment under the original Medicare program. We applaud you for your leadership and commitment in strengthening the Medicare Physician Payment System and advancing value-based care.

Below, APG will first provide (I) a brief description of our organization, followed by (II) a summary of the GOP and Democratic Doctors Caucuses' questions, (III) APG's comments regarding the Patients First Act, (IV) APG's responses to the RFI questions on Offsets, and (V) our conclusion. Together they reflect the voice of APG's membership and the commitment to working with the Caucuses to ensure that all Americans have consistently accessible, high-quality, equitable, person-centered health care.

I. About America's Physician Groups

APG is a national association representing more than 300 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models in original Medicare and in capitated and delegated relationships with health plans in Medicare Advantage (MA). APG members collectively employ or contract with approximately 260,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including an estimated one in four Americans and one in three MA enrollees.

APG's motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, rather than being paid by plans on a fee-for-service basis. Delegation of risk from all payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage populations of patients in more constructive ways than if our members were merely compensated for the units of service provided.

II. Summary of the RFI

The RFI aims to garner input for the GOP and Democratic Doctors Caucuses on strengthening the Medicare Physician Payment system and on offsets needed to cover cost of legislation. APG appreciates that the GOP and Democratic Doctors Caucuses' willingness to take a comprehensive approach towards changes in MACRA and Medicare Physician Payment System to support the all-important movement to value-based health care.

Key questions in the RFI are the following:

- What specific offsets or "pay-fors" within the Medicare program or the broader health care system should the bill sponsors consider funding a permanent, inflation-based physician payment update?
- Are there any areas in the Medicare system where we systematically overpay for services that could be provided in a less expensive setting of care?
- Are there ways we could shift care to less expensive settings without compromising patient access?

III. APG's Comments

Patients First Act

APG supports the excellent work that both the Center for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI) have accomplished in moving the U.S. health care system toward greater value-based health care. Despite recent signs of a pickup in the growth of ACOs following a long slowdown[1] -- for example, with a 4.4 percent increase in the number of beneficiaries attributed to MSSP ACOs from 2025 to 2026[2] -- changes are needed to spur even faster growth of these models. Below are our comments on provisions of the Patients First Act that APG believes will support the growth and foster greater adoption of ACOs and other value-based models.

A. **Providing Annual Payment Updates to Cover A Portion of Practice Cost Inflation and Modifying Physician Fee Schedule Budget Neutrality:** APG strongly support the bill's proposed shift to annual inflation-based payment updates tied to the Medicare Economic Index and to an increase to the budget neutrality threshold. Physicians remain the only Medicare provider type without a reliable inflationary update and the sustained erosion in real payment that has resulted has destabilized practices, accelerated consolidation, and threatened patients' access to care, particularly in rural and underserved communities. Tying an annual inflation update to the MEI would bring physician payment into greater alignment with the actual cost of delivering care. Similarly, raising the decades-old budget neutrality threshold would ease the zero-sum dynamic that currently pits specialists against primary care and constrains CMS's ability to invest in new payment models and quality improvement. Together these reforms would provide a more durable and predictable foundation that physical practices need. They would position practices far better to invest in coordinated value-based care and accept elements of payment risk, rather than simply remaining in a fee-for-service environment and facing a potential payment "cliff" from one year to the next.

B. **The Primary Care Hybrid Payment Model:** APG supports the bill's creation of a new hybrid monthly primary care payment model, which would offer a meaningful step away for many physician practices from a purely fee for service structure and toward one that better supports value-based care. Practices receiving hybrid payments would be better able to support critical features of value-based care, including care coordination, population

[1] See Markovitz AA, Gozalo PL, Ryan AM. Participation and attrition in the Medicare Shared Savings Program. Health Aff Sch. 2025 Apr 1;3(4):qxaf067. doi: 10.1093/haschl/qxaf067. PMID: 40224396; PMCID: PMC11992558.

[2] See https://www.cms.gov/newsroom/fact-sheets/2026-medicare-accountable-care-organization-initiatives-participation-highlights.

health management, and other non-visit-based work that primary care physicians engaged in value-based models must perform. The financial supports provided via hybrid payments hold the potential to improve the stability of primary care practices and strengthen patients' access to consistent longitudinal care.

However, we do not support the provision of the legislation in section 102 that would define an "excluded practice" ineligible to participate in the model based on such factors as corporate structure; physician or designated health care practitioner ownership (e.g., rendering ineligible organizations in which physicians or designated health practitioners constituted fewer than 50 percent of the members); and corporate governance (e.g., excluding an organization that requires a majority vote by physicians or designated health care practitioners to remove any other physician directors or officers).

Although we share the caucuses' goal of preserving physician autonomy and countering the market forces driving consolidation, these conditions of eligibility are (1) overly intrusive into the business structure of modern health care enterprises and (2) risk penalizing integrated physician-led value-based care organizations, whose governance and capital arrangements reflect the scale needed to take on risk, invest in care coordination infrastructure, and, in turn, support the existence of smaller independent practices. A practice's ownership or board composition is a poor proxy for whether physicians direct clinical care or patients receive high-quality coordinated services. We urge the caucuses instead to define eligibility around an entity's value-based performance and on whether physicians or others possess clinical decision-making authority. Value-based performance could be assessed using metrics already established, such as an ACO's shared savings record, achievement of quality scores, and total cost of care benchmarks, so that practices achieving strong outcomes in quality and cost efficiency would qualify to receive hybrid payments regardless of their capital structures. Clinical decision making would be evaluated by examining who develops and controls the clinical protocols and treatment decisions. Using such criteria to determine eligibility would ensure that practices doing the most to advance accountable care are not excluded simply based upon of how they are governed.

Freezing Qualifying Participant Thresholds: APG supports the freeze of the qualifying APM participant threshold at 50 percent for three years along with the Secretary's added flexibility to lower thresholds further when needed to encourage participation in new models. The Quality Payment (QP) threshold has risen steadily under current law. Each increase raises the bar that physicians in value-based models must clear to earn advanced APM incentive payments and avoid MIPS reporting altogether. This squeeze occurs even as many practices are still building the infrastructure and risk bearing capacity needed to succeed in value-based arrangements. Freezing the threshold would provide physicians and practices with greater predictability as they plan multi-year investments in care coordination, creation of data infrastructure, and population health management – features that become increasingly important, for example, as an ACO grows and adds additional practices to its provider network.

C. **Advanced APM Incentives**: Although APG supports the bill's split conversion factor approach, which would provide qualifying APM participants with an additional 0.5 percentage point above the non-qualifying update, APG urges the caucuses to go further and reinstate a direct advanced APM incentive payment. The five percent APM incentive payment authorized under MACRA expired after 2024, a development that removed a critical reward for physicians who took on financial risk and made the operational investments required to participate in advanced APMs. A modest differential in the annual conversion factor update is not an adequate substitute for a direct incentive payment, particularly for practices that are still absorbing the upfront cost of maintaining a care coordination staff and establishing new data infrastructure.

By contrast, restoring a meaningful APM incentive payment alongside the QP threshold freeze would send a clear signal that Congress intends to reward and support the transition to value-based care. Since it will take three to four years for the differential conversion factor to compound into a meaningful difference in payment between

Advanced APM and non-APM providers, APG also recommends a transitional bonus to support retention and ongoing adoption of risk bearing models. This bonus should correspond to physicians' performance in the specific performance year rather than being calculated and paid on a delayed basis. Currently the ACO would qualify in 2024, payment would be calculated in 2025 and paid in 2026. The net effect is that positive performance is only rewarded financially two years after it has occurred, whereas it should be rewarded sooner.

D. **Transparency for the Center for Medicare and Medicaid Innovation:** CMMI was designed to test models according to criteria established by Congress to determine if new approaches to providing care to patients could improve quality, reduce spending, or both. Under the law, if an approach met these criteria, the Secretary of Health and Human Services would have authority that previously resided with Congress to adopt it directly into the Medicare program. However, Congress only shared this authority with the Executive branch through MACRA and did not relinquish it. In fact, since the inception of CMMI, Congress has passed legislation multiple times that affects CMMI models, including making them permanent. CMMI should support this shared authority by ensuring transparent, detailed, and timely reporting on the performance of models, enabling Congress to make informed decisions about legislative actions on models. APG supports the proposed legislation's requirement of notice and comment rulemaking for any CMMI mandatory model as well as for major model changes. However, APG believes that a more formal reporting process to Congress should also be required, so that Congress could make periodic adjustments in the QP threshold, modification of incentive payments, or increasing funding for rural practices – all critical steps for ensuring that the movement to value-based care continues.

E. **Transition to the POINTS Framework:** APG reiterates our support for replacing MIPS with the Patient Outcome Improvement National Tabulation System (POINTS) and for establishing a physician and clinician majority task force at CMS to develop the underlying quality metrics. A new program should be structured around passive data collection, such as claims data, that addresses physician and patient administrative burden. The MIPs process measures should be replaced with a limited number (e.g., five or fewer) outcome measures that reflect results that are meaningful to patients. A simplified, clinically grounded framework designed by practicing physicians will be a meaningful improvement over the current MIPS measure set, which is administratively burdensome, outdated, and reflective of "box-checking" exercises that clinicians deem largely irrelevant to clinical care. However, APG believes that the bill should do more to use POINTS as a genuine on- ramp to advanced APMs rather than having it be a long-term "destination," as MIPS has become. As currently structured, a well -designed POINTS framework could inadvertently reduce the urgency that physicians feel to move into a risk bearing value-based arrangement since it will lower the burden and penalty exposure of remaining in fee-for-service. APG urges the caucuses to build stronger structural incentives into POINTS, such as escalating performance expectations over time or explicit glide path requirements tied to APM readiness. In this way, the POINTS program would encourage physicians to continue moving toward advanced APM participation.

IV. RFI Questions regarding Offsets for Legislation:

A. Site Neutral payments: APG encourages the caucuses to consider incorporating site neutral payment reforms, although depending on their scope, these may or may not amount to offsets to the costs of the Patients First Act's payment improvements. APG believes that site-neutral payment is directionally the correct way to proceed but has concerns about the short-term impact on the finances of many hospital and health systems and proposes that these reforms proceed in gingerly fashion.

Specifically, APG supports adopting the Medicare Payment Advisory Commission's (MedPAC) proposal to align payment across hospital based and non-hospital-based settings for 66 ambulatory procedures that MedPAC has identified as clinically appropriate for site neutral treatment while preserving higher payment for the 108 primarily hospital -based services under MedPAC's budget-neutral rebalancing. CMS has begun to move in this direction administratively, proposing site-neutral payment for imaging-without-contrast services in the CY 2027 proposed OPPS proposed rule, building on last year's site-neutral provision for drug administration services. However, these regulatory steps touch only a small fraction of the MedPAC proposal that has identified 108 procedures as appropriate for site neutral treatment, thus leaving the bulk of MedPAC's recommended package unaddressed and subject to reversal or delay in future rulemaking.

Because MedPAC's proposal is designed to leave aggregate Medicare spending unchanged in the short term while correcting the financial incentives that currently drive site-of-care decisions rather than clinical ones, it offers a fiscally responsible complement to the bill's MEI- based updates and budget neutrality reforms. Over time, removing the payment differential that rewards care delivered and higher cost in hospital- based settings for clinically equivalent lower acuity services could ease unnecessary spending growth, helping to sustain the durable, predictable payment system this bill is designed to create without adding to the federal budget impact. Codifying the fuller MedPAC package within the Patient's First Act would provide a permanent site neutral savings to help finance the bill's payment improvements rather than leaving the scope and pace of reform to CMS's discretion.

B. **Reductions in Medicare Advantage Payments**: Using MA as a "pay-for" is fiscally expedient but clinically indiscriminate, and it would come at a direct cost to the beneficiaries that many APG member organizations serve every day.

APG's members operate under capitated, accountable, and increasingly two-sided risk arrangements — models in which physician groups accept both the upside and downside financial risk for the total cost and quality of care their patients receive. These arrangements, encouraged by CMS and Congress for more than two decades, align physician incentives with patient outcomes rather than service volume. The evidence is consistent: physician organizations in two-sided risk consistently outperform fee-for-service and one-sided models on measures of preventive care, chronic disease management, avoidable hospitalizations, and total cost of care.

A blunt, government-wide reduction to MA benchmark payments (or other payment methods such as quality bonuses) does not distinguish between plans and provider arrangements that deliver superior value and those that do not. It falls with equal force on physician groups that have invested heavily in care coordination, behavioral health integration, home-based care, and quality infrastructure to succeed in two-sided risk as it does on arrangements that have made no such investment. We are concerned that using MA as a pay-for would produce the following consequences for beneficiaries and the delivery system. Reducing the benchmark shrinks the very revenue stream that supports care managers, home visits, remote monitoring, and other services traditional fee-for-service Medicare does not cover — services disproportionately relied upon by dual-eligible, chronically ill, and underserved beneficiaries.

In sum, APG respectfully urges the caucuses to consider the following in the quest for offsets:

- Reject the use of MA payment reductions as a general-purpose budgetary offset for legislation unrelated to Medicare policy.
- Pursue precision, not blunt force: target documented sources of overpayment (e.g., coding intensity, unlinked chart reviews) rather than reducing the benchmark across all plans and arrangements uniformly.

- Protect and strengthen two-sided risk pathways, including by preserving Advanced Alternative Payment Model incentives and ensuring physician groups taking on downside risk are not penalized alongside arrangements that take on none.
- Require CMS to assess and report the impact of any proposed MA savings provision on beneficiaries' access to accountable, capitated, and two-sided risk arrangements between physician groups and MA plans before enactment.

APG's members have spent decades building the infrastructure of coordinated, accountable care because they believe — and the data show — that it produces better outcomes for patients at a more sustainable cost to the system.[3] We welcome the opportunity to work with the caucuses on program integrity solutions that achieve savings without undermining beneficiary access to high-quality, value-based care.

V. Conclusion

APG commends the Republican and Democratic Doctors Caucuses for the commitment to ensuring that as a nation we are moving forward on providing high -quality care. We look forward to working with the GOP and Democratic Doctors Caucuses as the ideas are refined and finalized. If you have any questions, please contact Valinda Rutledge, Executive Vice President of Policy and Advocacy, at VRutledge@apg.org.

Sincerely,

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America's Physician Groups
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[3] The following published articles demonstrate the superior outcomes achieved by APG groups operating in two-sided risk relationships with MA plans:

- Cohen, K. R., B. Vabson, J. Podulka, N. J. Smith, E. Everhart, O. Ameli, K. Catlett, M. S. Jarvis, C. Goldzweig, J. H. Kuo, and S. Dentzer. 2025. Medicare risk arrangement and use and outcomes among physician groups. JAMA Network Open 8(1):e2456074. https://doi.org/10/1001/jamanetworkopen.2024.56074
- Vabson B, Cohen K, Ameli O, et al. Potential spillover effects on traditional Medicare when physicians bear Medicare Advantage risk. Am J Manag Care. Published online February 26, 2025. https://doi:10.37765/ajmc.2025.89686
- Cohen K, Vabson B, Podulka J, et al, Health Outcomes in Full Risk Medicare Advantage versus Traditional Medicare. Am J Manag Care. Published online May 9, 2025 (volume 31). https://doi:10.37765/ajmc.2025.89740
- Cohen K, Vabson B, Podulka J, et al, Health Outcomes of Dually Eligible Beneficiaries Under Different Medicare Payment Arrangements. Am J Manag Care. 2026; 23(5):26270. https://doi.org.10.37765/ajmc.2026.89827
- Cohen K, Catlett K, Podulka J, Health Outcomes of Socially Vulnerable Populations in Different Medicare Payment Arrangements. Am J Manag Care. 2026;32(5):262-270. https://doi.org/10.37765/ajmc.2026.89827