

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

September 15, 2026

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

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

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

Primary Care as the Foundation of the Health Care System

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

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

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

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

Modernizing Medicare through Hybrid Payment

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

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

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

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

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

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

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

Hybrid Model Eligibility for Success

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

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

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

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

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

Eliminating Cost-Sharing in the Hybrid Model

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

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

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

Strengthening Behavioral Health Integration

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

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

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

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

The Congressional Responsibility to Invest in Primary Care

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

Quality Reform Task Force Representation

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

Recommendations

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

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

Conclusion

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

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

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

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

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

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

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

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

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

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

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