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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Subcommittee on Health

of the

U.S. House of Representatives

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

September 15, 2026

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share the hospital field's comments on legislative proposals that are to be considered before the Energy and Commerce Committee's Subcommittee on Health on Sept. 15.

H.R. 9693, Patients First Act of 2026; H.R. 8163, Provider Reimbursement Stability Act of 2026

The Patients First Act of 2026 ties physician reimbursement to an inflation-based update of the Medicare Economic Index (MEI) -1%. The bill also establishes a primary care hybrid payment pilot program that pays primary care physicians a per-member-per-month (PMPM) payment. Additionally, the Patients First Act replaces the Merit-based

Incentive Payment System with the Patient Outcome Improvement National Tabulation System (POINTS) program, which creates a physician- and clinician-led task force at the Centers for Medicare & Medicaid Services (CMS) to develop quality metrics to streamline and reduce administrative burden. The bill freezes alternative payment model thresholds for three years.

Lastly, the Provider Reimbursement Stability Act of 2026 and Title IV of the Patients First Act both increase the budget neutrality threshold in the Medicare Physician Fee Schedule (up to $54.3 million in the Provider Reimbursement Stability Act and up to $57.64 million in Title IV of the Patients First Act).

AHA Response:

The AHA appreciates efforts to address the longstanding need for long-term physician payment reform and supports elements of these bills to increase the budget neutrality threshold under the physician fee schedule and to add an annual inflationary update to physician payment rates. Continued payment declines for physicians are unsustainable, particularly considering the physician shortages facing the country, and updates to the physician fee schedule conversion factor have not kept pace with inflation. We also support freezing the current alternative payment model participation thresholds to further advance value-based care adoption.

We would like to draw the committee's attention to a few provisions in the bills. The PMPM capitated payment demo in the Patients First Act is restricted to independent clinicians. Additionally, the POINTS bonus program is for high-performing independent practitioners only and creates limits on POINTS bonus payouts for non-independent providers at 50% of the total adjustment and redistributes the delta to independent providers.

We would encourage the committee to adjust the Patients First Act to allow for hospital and other provider-based clinicians to receive the full benefits of the PMPM capitated payment demo and the POINTS program bonus payouts. To fully achieve a more stable physician payment system and incentivize higher-quality care, all providers should be able to access these payments.

Lastly, we are concerned that an annual update based on the MEI -1% is not sufficient to account for the existing shortcomings in physician reimbursement. Medicare's physician fee schedule conversion factor, which determines physician payment, declined by 13% in real dollars from 2001 to 2026. The actual reduction in payments, when accounting for inflation, is a staggering 33%.[1] Therefore, we would urge the committee to use a higher update to physician reimbursement that more fully accounts for inflation.

[1] https://www.ama-assn.org/system/files/2026-medicare-updates-inflation-chart.pdf

H.R. 8622, **Medicare Physician Data-driven Performance Payment System Act of 2026**

This bill would replace the existing Merit-based Incentive Payment System (MIPS) with the Data-driven Performance Payment System (DPPS). The DPPS freezes the performance threshold at 75 points for three years to promote stability in MIPS. The Government Accountability Office (GAO) is commissioned to conduct a study on an alternative threshold methodology and offer recommendations to Congress and the Department of Health and Human Services (HHS). The bill also eliminates the current bonus and penalty payment adjustments in MIPS and links physician performance to annual payment updates. Additionally, the legislation requires CMS to provide quarterly performance feedback and protect clinicians from receiving negative adjustments if the agency does not deliver timely quarterly reports. The bill also provides additional incentive payments for smaller practices in rural and underserved areas to invest in care management and value-based care participation.

AHA Response:

The AHA appreciates this bill would replace MIPS with a similar system that we believe would preserve stability in physician payments and quality reporting while seeking additional refinements to how physician performance is assessed. In particular, we agree that it is necessary to prevent the performance threshold from rising without adequate evidentiary support and would value the opportunity to review findings from a GAO study and provide recommendations on behalf of our members and their clinical staff. In addition, we agree that quarterly feedback reports on measure performance would help clinicians improve their performance and appreciate that CMS would be held accountable for the timely provision of this data. Finally, we acknowledge the need for additional support for smaller practices, especially those in rural areas, to compete on a level playing field and, thus, would support additional incentive payments to these practitioners.

H.R. ____, **Health Care Cybersecurity and Resiliency Act of 2026**

This bill would require the Secretary of HHS and the Director of the Cybersecurity and Infrastructure Security Agency to coordinate to improve cybersecurity in the healthcare and public health sectors.

AHA Response:

We appreciate that the legislation would include grant funding opportunities to support adoption of cybersecurity best practices and appreciate the inclusion of provisions to bolster education and workforce training as well as cross-sector coordination. The AHA encourages the committee to provide further clarity on the applicability of cybersecurity standards to third-party vendors. Most protected health information (PHI) data breaches

reported to the Office of Civil Rights resulted from hacking incidents targeting non-hospital healthcare providers, including third-party service and software providers. One example is the Change Healthcare cyberattack, which resulted in the theft of 190 million Americans' PHI — the largest healthcare data breach in history. We believe third parties handling health information should be held to the same privacy and security standards as covered entities and business associates and encourage the committee to add a definition for third parties in Sections 2 and 8 of the legislation.

H.R. 9908, Rural Hospital Cybersecurity Enhancement Act

The bill would direct HHS to create a comprehensive workforce strategy to train cybersecurity professionals and develop partnerships to expand the cybersecurity workforce for rural hospitals.

AHA Response:

The AHA supports this legislation, as it would give rural hospitals tools to strengthen cybersecurity and mitigate risks associated with harmful cyber threats.

H.R. 1254, Rural Obstetrics Readiness Act

The bill seeks to improve obstetric emergency preparedness in rural healthcare settings, especially for those hospitals without dedicated obstetric units. The legislation focuses on training for practitioners in rural facilities that lack obstetric service units, establishes grant funding for rural obstetric readiness, creates a teleconsultation pilot program to support urgent maternal healthcare and directs HHS to study rural obstetric unit patterns and closures.

AHA Response:

The AHA supports this legislation, as it will help address maternal health needs in rural areas.