



September 15, 2026

The Honorable Morgan Griffith
Chairman, Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member, Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chair Griffith and Ranking Member DeGette:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 124,500 family physicians and medical students across the country, I write in response to today's hearing examining legislative proposals to reform Medicare provider payment and bolster health care cybersecurity. We recognize the limited number of days left in the legislative calendar for this Congress, and we sincerely appreciate that the Subcommittee is prioritizing movement on several legislative priorities that stand to improve the practice of medicine for family physicians and, most importantly, benefit their patients.

Specifically, the AAFP applauds the Subcommittee's consideration of long-overdue reforms to the Medicare physician payment system, as proposed in the *Patients First Act* (H.R. 9693), that would alleviate the looming 1.19 or 1.68 percent reduction to payment rates for 2027 (depending on advanced alternative payment model participation). We believe that the more comprehensive nature of this legislation lays the best foundation for positive changes moving forward, but we also appreciate the Subcommittee's consideration of two other pieces of legislation that propose more targeted changes to Medicare physician payment: the *Provider Reimbursement Stability Act* (H.R. 8163) and the *Medicare Physician Data-driven Performance Payment System Act* (H.R. 8622). Additionally, the AAFP applauds the Subcommittee for considering the *Rural Obstetrics Readiness Act* (H.R. 1254), legislation that would help address obstetric emergencies in light of our nation's ongoing maternity care desert crisis.

However, the AAFP would also like to register significant concerns with the Subcommittee's consideration of the *Ensuring Community Access to Pharmacist Services Act* (H.R. 3164). We appreciate and share the goal of improving health outcomes and access to care in rural and underserved communities, but the approach laid out in this legislation is short-sighted and, most concerning, could endanger patient safety. We believe there are other well-designed proposals that could achieve our shared goal on behalf of patients in all communities, which we discuss in further detail below.

Modernizing Medicare Physician Payment for Primary Care

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), a landmark piece of legislation intended to reform physician payment after years of significant payment reductions under the sustainable growth rate. Unfortunately, while MACRA aimed to shift physician payment away from fee-for-service and towards value-based payment (VBP), it has largely failed to do so. Instead, family physicians across the country continue to face

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unprecedented financial and administrative pressures. This is because a number of foundational flaws remain embedded in the Medicare Physician Fee Schedule (MPFS) that have made it difficult for many physician practices to stay afloat financially, let alone make the necessary investments to move towards VBP participation.

Fee-for-service payment, such as the MPFS, has historically underinvested in primary care. On average, the United States only spends three to five cents of every health care dollar on primary care. Across payers, Medicare spends the least on primary care.¹ This has ripple effects, given that most other payers peg their payment rates to Medicare rates. This underinvestment is compounded by the fact that the MPFS is the only major Medicare provider payment system without a permanent inflationary update. What this has translated to in reality is a 33 percent decline in physician payments between 2001 – 2025, when adjusted for inflation. The need for reform remains evident as the Centers for Medicare and Medicaid Services (CMS) recently released the Calendar Year 2027 MPFS proposed rule, which includes a reduction to physician payment due to the lack of an inflationary update and an expiring Congressionally-provided increase.

Further, overly-restrictive budget neutrality requirements have hamstrung the ability for CMS to invest appropriately in all of the services that patients need and risk stunting coverage of innovative services or technologies. These requirements mean that adding new services or increases to existing codes result in either specific offsets to other services or across-the-board cuts.

Without meaningful reform, continued financial instability threatens patient access to comprehensive primary care services and will only further accelerate consolidation within the health care system. **Thankfully, the bipartisan *Patients First Act* (H.R. 9693), led by Drs. Kim Schrier, John Joyce and Greg Murphy, would take important steps to address these longstanding shortcomings.**

The legislation addresses five key categories of interest to family physicians:

- It stabilizes payment by providing an annual inflationary update equal to the Medicare Economic Index increase minus one percent, with a floor and a ceiling for updates;
- It establishes a five-year primary care pilot program that would provide a prospective, per-member-per-month payment to clinicians in independent practices;
- It replaces the Merit-based Incentive Payment System with a new program and establishes a physician-led quality measurement task force at the Department of Health and Human Services to ensure that each specialty has more clinically relevant quality measures, decided upon by their peers;
- It reforms long-outdated budget neutrality requirements for physician payment, which have not been changed since the 90's; and
- It freezes the existing advanced alternative payment model threshold for three years while giving the Secretary additional flexibility to further reduce thresholds if necessary to drive participation into new models.

While these reforms will not solve all of the problems with physician payment, they are essential first steps. **The AAFP is pleased to support this legislation and we strongly encourage the Subcommittee to advance the bill in a subsequent markup so that it can be passed by the full House of Representatives before the end of this Congress.**

Relatedly, we appreciate the Subcommittee's consideration of the Provider Reimbursement Stability Act (H.R. 8163), standalone legislation that informed the budget neutrality provisions of the *Patients First Act*, and the *Medicare Physician Data-driven Performance Payment System Act* (H.R. 8622), which proposes reforms to the flawed Merit-based Incentive Payment System (MIPS) implemented by MACRA. Each of these bills tackles a specific challenge with existing physician payment structures, which must be reformed in order to improve the financial viability of primary care practices across the country and recruit more future physicians into the field of family medicine.

Treating Obstetric Emergencies in Maternity Care Deserts

Over the last few years, family physicians and their colleagues in obstetrics and gynecology have been sounding the alarm about the concerning decline in access to maternity care services and corresponding health outcomes. This crisis has been particularly pronounced in rural communities, where family physicians often serve as the only community-embedded physician and provide prenatal care, labor and delivery services, postpartum care, and ongoing primary care for both parent and child.

More than one-third of U.S. counties are maternity care deserts, meaning they have no hospital or birth center offering obstetric care and no obstetric clinicians. These counties are home to approximately 2.4 million women of reproductive age and 149,000 births annually.ⁱⁱ Further, more than half of all U.S. counties lack a hospital with labor and delivery services, affecting nearly 370,000 births each year. Between January 2024 and May 2026, at least 96 hospital labor and delivery units closed across 35 states. In nearly 60 percent of affected counties, the closed unit was the community's only birthing facility.ⁱⁱⁱ

The closure of rural hospitals and obstetric units, combined with persistent workforce shortages, has left many communities without local maternity services and has increased the distance patients must travel to receive care. Many rural facilities now lack the resources, training opportunities, equipment, and specialist support necessary to respond effectively to obstetric emergencies.

The AAFP is proud to support the *Rural Obstetrics Readiness Act* (H.R. 1254), led by Subcommittee member Representative Kelly. This bill would strengthen emergency obstetric care capacity by establishing and expanding federal grant programs through the Health Resources and Services Administration (HRSA). It would support training for health care professionals, workforce development initiatives, and the purchase of equipment necessary to manage obstetric emergencies in rural hospitals and facilities serving maternity care shortage areas.

Importantly, the bill recognizes that many rural facilities no longer maintain dedicated labor and delivery units but still encounter pregnant and postpartum patients requiring immediate care. This proposal would provide training opportunities for clinicians practicing in these settings and expand access to telehealth consultation and support, helping rural clinicians deliver evidence-based care during obstetric emergencies. We share Representative Kelly's goal of improving maternal and infant health outcomes, strengthening rural health systems, and supporting the family physicians and other clinicians who serve as a lifeline for patients in rural America, and we urge the Subcommittee to advance this legislation in a markup in the coming weeks.

Expanding Access to Primary Care by Appropriately Trained Physicians

The AAFP wholeheartedly agrees with this Subcommittee and your colleagues in Congress that additional policies are needed to better support the needs of our nation's seniors, especially those in rural areas – however, we caution against the approach being considered today in the *Ensuring Community Access to Pharmacist Services Act* (H.R. 3164). The legislation as written would permanently expand Medicare reimbursement to cover independent diagnosis and treatment of certain respiratory viruses by pharmacists.

The AAFP does not believe this legislation will meaningfully improve access to care but instead risks disruptions to whole-person continuous primary care delivered by trained primary care clinicians. We are concerned that unintended consequences such as fragmented care, misdiagnosis, additional costs, and time to a patient to correct an incorrect care plan could occur. We appreciate the inclusion of new language to highlight the importance of physician-pharmacist collaboration, but the proposal still promotes and incentivizes delivery of direct patient care beyond the appropriate scope for a pharmacist.

Pharmacists are integral to the delivery of comprehensive health care. A pharmacist's unique role and training ensures the safe, effective, and appropriate use of medications. However, pharmacists do not receive robust training to diagnose conditions nor to provide a care plan that goes beyond the administration of medications to treat a condition. Additionally, a survey with U.S. voters showed that 95 percent said it is important for a physician to be involved in their diagnosis and treatment decisions.^{iv}

We acknowledge the expanded and critical role pharmacists played during the COVID-19 public health emergency after receiving additional federal authority, such as the ability to administer COVID-19 testing and vaccines. The pandemic showed that it may be necessary and appropriate to temporarily allow some expanded responsibility during times of crisis, but this should not be seen as a universally appropriate approach to other conditions, such as strep throat, respiratory syncytial virus (RSV), and the flu. We also remain concerned by the bill's broad language that allows pharmacists to "address a public health need related to a public health emergency."

Our principal concern with H.R. 3164 is patient safety. Pharmacists frequently lack access to a patient's full medical records and have limited training on patient history, physical exams, differential diagnoses, and testing, meaning they would be granted the ability to provide medical treatment without the critical knowledge needed to make informed and appropriate decisions for each individual patient. Pharmacists do not possess the skills, training, experience, or knowledge needed to provide comprehensive medical care, health maintenance, and preventive services for a range of medical and behavioral health issues. Many patients, especially seniors who have a higher prevalence of chronic conditions, require follow-up care and management services that primary care physicians are appropriately trained to provide.

A negative diagnostic test does not negate the need for further evaluation or treatment. However, Medicare beneficiaries who receive a negative test result from a pharmacist may not seek additional diagnostic or treatment services from their primary care physician, which could lead to untreated conditions and adverse outcomes. Pharmacists do not have access to requisite technologies, such as an x-ray, or the training to perform additional services, such as listening to a patient's lungs, that are necessary to ensure that the patient is not

suffering from an acute condition beyond a negative strep, RSV or COVID test. In addition, given the lack of two-way communication between pharmacists and physicians, seniors could be subject to duplicative testing (and thus, increased costs) while the physician is diagnosing the actual cause of illness.

Again, we acknowledge the vital role that pharmacists play in providing comprehensive care to most patients and fully support a collaborative and team-based health care model. Although pharmacists should not independently diagnose, they are qualified to deal with issues of medication use, medication tolerability, patterns of medication use, assessment of therapeutic response, and dosing adjustments. It is clear however that patients are best served when their care is provided by an integrated practice care team led by a physician. Physician-led team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients.^{v,vi,vii}

Instead of promoting fragmented delivery of services, Congress should be prioritizing the delivery of comprehensive, whole-person primary care by passing policies that strengthen the primary care workforce at all levels. Allowing pharmacists to test for COVID-19 and to provide additional vaccines during the public health emergency was a band-aid solution to a systemic problem: primary care physicians face numerous hurdles when it comes to providing comprehensive, continuous patient care, especially to the most vulnerable populations and during times of crisis.

The Subcommittee should advance health care workforce reforms that strengthen primary care education and training, encourage primary care physicians to work in underserved and rural communities, and ensure that Medicare payments for primary care services are sufficient and stable. In addition, given the constant uncertainty regarding Medicare Part B funding, we must acknowledge that adding pharmacists to the list of Part B providers would have a significant fiscal impact and only further destabilize Medicare payment for physicians and other Part B clinicians. This continued erosion of finite resources could jeopardize the ability of family physicians and others to deliver care to all the Medicare beneficiaries in their community who need it.

While we appreciate the intent behind H.R. 3164, the unintended consequences of this bill could be incredibly detrimental to the state of our nation's primary care system and the quality of care patients receive. **We urge the Subcommittee to instead focus on policies that strengthen and invest in a patient's relationship with their usual source of care.**

Thank you for holding this legislative hearing to consider several important pieces of legislation. The AAFP looks forward to continuing to partner with you to take meaningful steps toward improving the practice environment for primary care and access to whole-person care for patients in all communities. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Williams, M.D.", with a stylized flourish at the end.

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

ⁱ Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Park J. *The Cost of Neglect: How Chronic Underinvestment in Primary Care Is Failing US Patients: The Health of US Primary Care, 2025 Scorecard Report*. New York, NY: Milbank Memorial Fund; 2025. Accessed August 28, 2026. <https://www.milbank.org/wp-content/uploads/2025/02/Milbank-Scorecard-2025-ACCESS-v07.pdf>.

ⁱⁱ March of Dimes. Nowhere to Go: Maternity Care Deserts Across the U.S. 2026 Report. Arlington, VA: March of Dimes, 2026. <https://www.marchofdimes.org/maternity-care-deserts-report>.

ⁱⁱⁱ Ibid.

^{iv} American Medical Association. Patient Sentiment on Scope of Practice Expansion Survey. Chicago, IL: American Medical Association; 2024. Available at: <https://www.ama-assn.org/system/files/patient-sentiment-scope-practice-survey.pdf>.

^v David C. Chan Jr and Yiqun Chen, "The Productivity of Professions: Evidence from the Emergency Department," NBER Working Paper 30608 (2022), <https://doi.org/10.3386/w30608>.

^{vi} "Diffusion Of Innovation To Improve Health Care Value: Physician-Led Care Redesign," Health Affairs Forefront, March 14, 2019.

^{vii} Morrisette E, Brookshire M, Pinto Basto M. Boosting Physician Satisfaction: Lessons from Physician-Owned Practices. Bain & Company. October 4, 2024. Available at: <https://www.bain.com/insights/boosting-physician-satisfaction-lessons-from-physician-owned-practices/>.