AIMPA®

American Independent
Medical Practice
Association®

August 20, 2026

The Honorable John Joyce, M.D.
U.S. House of Representatives
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Murphy, M.D.
U.S. House of Representatives
407 Cannon House Office Building
Washington, DC 20515

The Honorable Kim Schrier, M.D.
U.S. House of Representatives
1110 Longworth House Office Building
Washington, DC 20515

Re: Request for Information on H.R. 9693, the Patients First Act of 2026

Dear Representatives Joyce, Murphy, and Schrier:

The American Independent Medical Practice Association (AIMPA) appreciates your bipartisan leadership in developing the Patients First Act of 2026 and the opportunity to respond to your Request for Information. AIMPA is a physician-led national advocacy organization representing more than 2,000 independent medical practices and over 14,000 physicians who care for more than 40 million patients each year. AIMPA physicians serve patients at more than 6,000 medical office locations and nearly 700 independent ambulatory surgery centers in 48 states and the District of Columbia.

AIMPA strongly supports the Patients First Act. It is a thoughtful, bipartisan response to the payment instability, administrative burdens, and hospital-driven consolidation

threatening community-based physician practices and patient access to affordable care. We commend the sponsors and staff for this important work and urge Congress to advance the legislation.

We propose targeted textual changes to prevent unintended consequences that would harm independent physician practices and undermine their ability to continue serving patients. With those safeguards, the Patients First Act can represent a major achievement for this Congress and an important step toward modernizing Medicare physician reimbursement.

Specifically, AIMPA recommends that Congress:

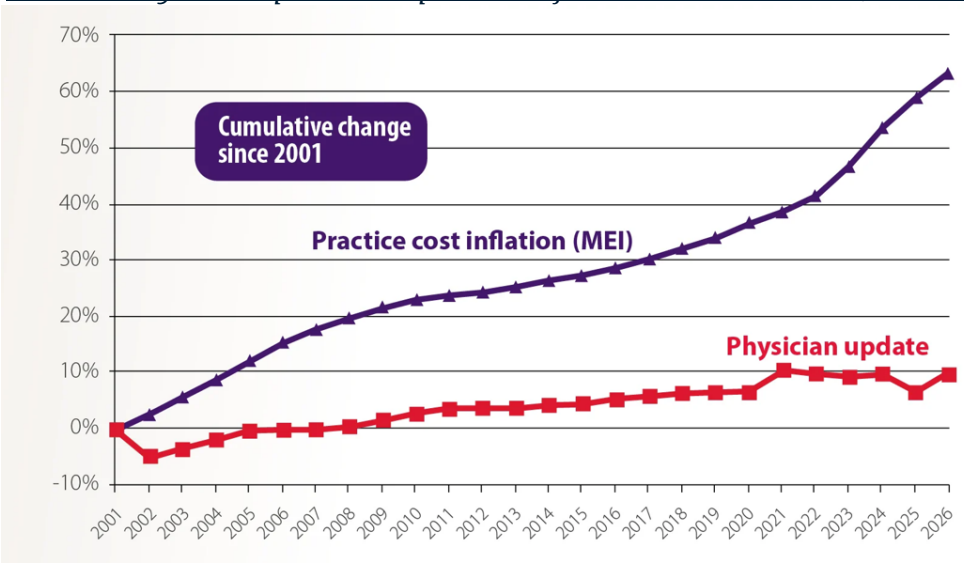
- Preserve the bill's annual update at Medicare Economic Index (MEI) minus one -- an important first step in fixing the flawed payment system for independent physicians -- as well as reforms that reduce the frequency, magnitude, and volatility of budget-neutrality adjustments.
- Clarify that the primary-care model's "excluded practice" criteria should target non-physician control of clinical care without inadvertently excluding physician-led practices that partner with management services organizations for support of nonclinical functions.
- Consider expanded site-neutral payment and 340B reform as responsible offsets that would strengthen competition and reduce costs for patients.

The Patients First Act's Payment Reforms Are Essential to the Future of Independent Practice

For more than two decades, Medicare physician reimbursement has failed to keep pace with the costs associated with operating a practice. After adjusting for inflation, Medicare physician reimbursement declined by approximately 33% between 2001 and 2026.

When reimbursement declines in real terms or swings unpredictably from year to year, independent practices have fewer resources to recruit staff, invest in care delivery, improve access for Medicare beneficiaries, and resist acquisition by a hospital or health system.

Medicare Physician Updates Compared to Inflation in Practice Costs (2001-2026)



Credit: American Medical Association

The Patients First Act begins to address these pressures through annual MEI-based updates, corrections for materially inaccurate utilization estimates involving certain newly unbundled services, and a 2.5% limit on year-to-year conversion-factor changes resulting from a budget-neutrality adjustment.

Raising and indexing the budget-neutrality threshold will reduce needless cuts and volatility

Raising the statutory budget-neutrality threshold from $20 million to $57.64 million in 2028 and indexing it to cumulative MEI growth every five years beginning in 2033 is especially important. The existing $20 million threshold was enacted decades ago and has lost substantial value to inflation. As a result, relatively modest changes in relative value units can trigger across-the-board conversion-factor reductions. The higher threshold should allow more targeted code and valuation changes without automatically cutting payments for every physician service.

Together with the bill's utilization-correction mechanism and conversion-factor variance limit, this reform should reduce avoidable payment swings, make payment more predictable, and empower practices to make multi-year investments in staff, equipment, facilities, and expansion of services to enhance patient access. In some years, it may also permit targeted increases to take effect without being diluted by an across-the-board offset.

The MEI-based update is an important first step toward durable payment reform

We applaud the bill's establishment of a predictable annual physician reimbursement update linked to the Medicare Economic Index, which measures changes in the cost of operating a medical practice, including wages, supplies, equipment, and other expenses.

This is a meaningful improvement. Physician practices cannot recruit additional physicians, nurses and other clinical staff, maintain offices, or invest in medical technology to support care delivery, when reimbursement remains essentially flat while the cost of providing care rises every year. Tying annual updates to MEI would begin to replace the damaging cycle of payment cuts, last-minute congressional interventions, and temporary relief with a more stable and rational payment system.

Under the bill, most physicians would receive an annual update based on MEI minus one percentage point, subject to safeguards ensuring that the update is no less than 25% and no more than 75% of MEI.

Physicians who qualify for the advanced alternative payment model (APM) conversion factor -- generally by meeting applicable participation thresholds in arrangements that hold clinicians accountable for the cost and quality of care -- would receive an additional 0.5 percentage-point update. That differential appropriately recognizes the investments and financial risk associated with value-based care while ensuring that physicians who continue to practice under the traditional Medicare fee schedule also receive an inflation-related update.

AIMPA strongly supports this reform. We encourage Congress to build on the important progress made by the Patients First Act by advancing a full, permanent annual MEI update in future legislation. That additional step would allow Medicare physician reimbursement to keep pace with the cost of caring for patients and help preserve the long-term viability of independent physician practice.

Align the 'Excluded Practice' Criteria with the Bill's Pro-Physician Objective

AIMPA's comments on the proposed primary-care payment model are limited to the definition of an "excluded practice." As currently drafted, that definition could inadvertently disqualify physician-owned and physician-led practices that

partner with management services organizations (MSOs), even when physicians retain complete authority over clinical care.

We recommend targeted textual changes to ensure that the criteria identify arrangements in which a non-physician entity controls medical decision-making without sweeping in MSO partnerships that help physicians remain independent through critically needed business support.

The exclusion should turn on whether a non-physician entity can direct, restrict, or override medical judgment. Physicians must retain ultimate authority over clinical standards, diagnostic and procedural decisions, the clinical qualifications and supervision of patient-care personnel, and the time needed to care for each patient.

By contrast, MSOs commonly provide administrative support for billing and collection, human resources, payer contracting, information technology, cybersecurity, procurement, real estate, compliance, and management of other nonclinical functions. Delegating responsibility for these business functions to an MSO does not relinquish physician control over the practice of medicine.

The bill also should avoid treating ownership percentages, voting rights, board composition, or protections involving nonclinical assets as automatic proxies for non-physician control of clinical care. MSO partnerships may allocate certain economic and administrative rights between the physician-owned professional entity and the MSO while reserving ultimate authority over clinical care to physicians. AIMPA therefore recommends that the exclusion criteria focus principally on whether a non-physician entity has the practical ability to direct, restrict, or override clinical judgment and not automatically exclude a practice based solely on its business or governance arrangements when physicians retain ultimate authority over clinical care.

Recognize the appropriate role of MSOs and private investment in healthcare

Federal policy should recognize an appropriate role for private investment in health care when physicians remain responsible for clinical care. MSOs can provide independent practices with the scale and expertise to open sites in underserved areas, develop ambulatory surgery, infusion, and clinical research capacities, recruit clinicians, adopt advanced technologies to support diagnosis and treatment of injuries, illness and disease, aggregate specialty data, participate in value-based arrangements, and manage complex reporting requirements.

These resources help physician-led practices deliver care in convenient, lower-cost settings and remain a competitive alternative to hospitals, health systems, and vertically integrated "pay-viders."

The benefits to patients are concrete. As just a few examples, AIMPA physicians report that MSO partnerships have enabled their independent practices to:

- Expand access to cancer care in rural Tennessee and northern Georgia.
- Accept insurance plans that competing hospitals do not accept. One New York oncology practice reports that MSO support has enabled it to participate in a broader range of insurance networks -- including Medicaid -- than many competing hospital-affiliated providers.
- Deploy an AI-assisted colonoscopy platform designed to improve the detection of precancerous polyps across 22 independent endoscopy centers in Georgia and southwest Florida.
- Move total joint procedures from higher-cost hospital settings to same-day ambulatory surgery centers and invest in advanced radiation therapy, genetic-testing, and precision-medicine capabilities outside hospital systems.

These examples illustrate the unintended consequences for patients of an overbroad exclusion test. As drafted, the definition could deny otherwise eligible clinicians access to the primary-care model because their physician-led practices obtain nonclinical support from an MSO. Exclusion from the model, combined with the loss of the operational resources that MSOs provide, could make it more difficult for independent physicians to expand services, adopt beneficial technology, and continue caring for their patients.

Over time, the resulting pressure could make hospital acquisition more likely, driving up cost, reducing patient access and accelerating consolidation.

The immediate effect is limited to eligibility for the primary-care payment model. But the definition could nevertheless disadvantage otherwise eligible clinicians and establish a consequential precedent by treating certain physician-led, MSO-supported practices as non-independent based on their business arrangements rather than who controls clinical care.

If later extended to specialists or incorporated into other reimbursement or regulatory policies, that approach could have much broader consequences for

independent practice. Focusing the criteria on actual control of clinical care would avoid those risks while preserving safeguards against non-physician interference in medical decision-making.

Responsible Offsets: Site-Neutral Payment and 340B Reform

The RFI asks how Congress can finance a stable, predictable physician reimbursement update and whether Medicare overpays for services that can be delivered safely in lower-cost settings. In response, AIMPA identifies two complementary reforms that could generate savings while reducing payment distortions that disadvantage independent practices and undermine patient access to high quality care.

Expand site-neutral payment

Medicare frequently pays more when the same service is furnished in a hospital outpatient department (HOPD) rather than an independent physician office or ambulatory surgery center. These payment differences incentivize hospital acquisition of physician practices in two ways.

First, depending on the location and regulatory status of the acquired practice, a hospital may convert the practice into an HOPD and receive higher facility-based payments for services that were previously paid under the Medicare Physician Fee Schedule.

Second, hospital employment of a practice's physicians may increase the volume of procedures and services that remain within the health system's existing HOPDs, where Medicare payments and beneficiary cost sharing are often higher.

Expanded site-neutral payment would address both incentives by paying the same amount for the same service when it can be furnished safely and effectively in a lower-cost setting, regardless of who owns the site. If an HOPD no longer commands an ownership-based payment premium for that service, a hospital would have less financial incentive to acquire a physician practice merely to convert its services to hospital billing or retain referrals within higher-paid hospital facilities.

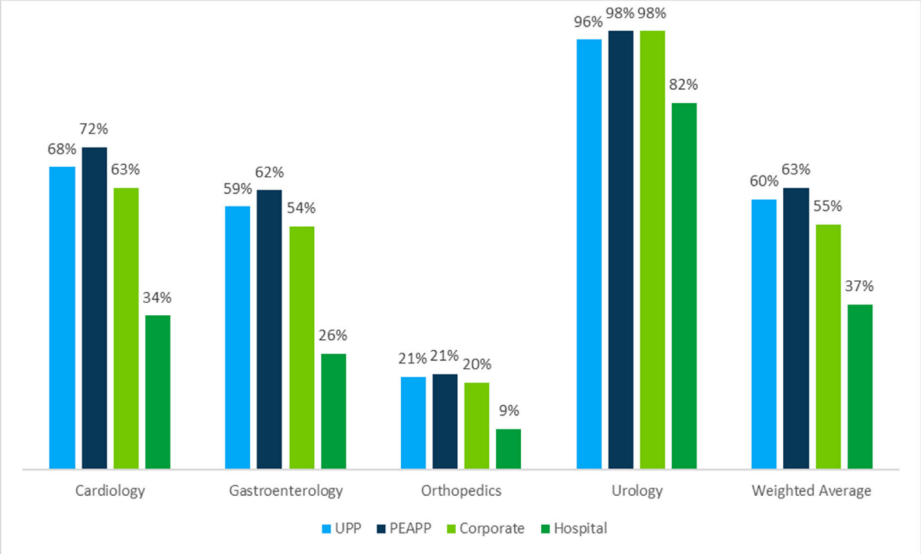
The evidence demonstrates both the fiscal and competitive importance of this reform. A recent study of 32 high-volume services across four specialties found that patients of hospital-affiliated physicians were substantially less likely to

receive care in a lower-cost physician office or ambulatory surgery center than patients of independent physicians whose practices were affiliated with MSOs.

Separately, the Congressional Budget Office estimated in 2024 that applying site-neutral rates to most services commonly furnished in physician offices at both on-campus and off-campus HOPDs would **reduce Medicare spending by approximately $157 billion over the 10-year period from 2025-2034**.

Expanded site-neutral payment would therefore reduce Medicare spending and beneficiary cost sharing, diminish the financial incentives for hospital acquisition of physician practices, and help independent practices remain independent. Congress should reinvest a portion of those savings in a permanent, inflation-based physician payment update -- replacing unjustified payment premiums for hospital outpatient settings with more stable support for physicians who keep care accessible and affordable in their communities.

Hospital-Affiliated Physicians Are Less Likely to Deliver Care in Lower-Cost Settings



Risk-adjusted probability of selected specialty-specific services being provided in lower-cost settings (ASC or office, combined), by specialty and affiliation model, Medicare (2022). Source: "Physician Practice Affiliation Drives Site of Care Cost Differentials: An Opportunity to Reduce Healthcare Expenditures," Journal of Market Access & Health Policy (2025).

340B reform

The 340B Drug Pricing Program permits eligible hospitals and certain other covered entities to purchase outpatient drugs at substantial discounts. Medicare, however, has generally reimbursed 340B hospitals through the Hospital Outpatient Prospective Payment System (OPPS) at average sales price (ASP) plus 6% for separately payable drugs, notwithstanding those hospitals' dramatically lower acquisition costs. The resulting margins can provide hospitals with substantial resources to expand their market share and acquire physician practices.

A recent CMS cost acquisition survey confirmed significant differences between the prices hospitals pay for drugs acquired through the 340B program and those acquired outside the program. Based on that survey, CMS has proposed paying 340B hospitals ASP minus 33.4% for 340B-acquired drugs beginning in 2027. CMS estimates that this more accurate payment rate would **reduce Original Medicare drug payments by approximately $4.55 billion and beneficiary payments by approximately $1.15 billion in its first year**.

Under current law, reductions in Medicare payments for 340B-acquired drugs must be implemented in a budget-neutral manner within the OPPS. The proposed reduction in drug payments therefore would be offset by higher OPPS payments for hospitals' non-drug items and services, leaving no net Medicare savings available to support physician reimbursement.

Congress should explore options to ensure that more accurate Medicare payment for 340B-acquired drugs produces federal savings that can help finance a permanent, inflation-based physician payment update. Doing so would reduce hospital drug-payment margins that can contribute to consolidation and reinvest federal resources in community-based physician practices that deliver high-quality care in lower-cost settings.

Conclusion

The Patients First Act recognizes that Medicare cannot preserve access, affordability, and competition while physician reimbursement erodes and independent practices disappear. AIMPA commends your bipartisan leadership and strongly supports the bill's MEI-based update and budget-neutrality reforms.

We respectfully ask Congress to clarify that the "excluded practice" criteria turn on actual control of clinical care rather than the delegation of nonclinical

business functions and to consider site-neutral payment and evidence-based 340B reform as responsible offsets.

AIMPA looks forward to working with you to advance this important legislation and would welcome the opportunity to discuss these recommendations.

Sincerely,

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