

Patients First Act of 2026 (H.R. 9693)

Summary of Key Medicare Physician Payment and Delivery System Provisions

Sponsor: Rep. John Joyce (R-PA) and bipartisan cosponsors

Introduced: July 15, 2026

Overview

The Patients First Act of 2026 is a broad physician payment reform package that would modify Medicare physician payment updates, establish a new hybrid primary care payment model, restructure portions of MIPS, strengthen the role of physician-led quality measurement, make changes to Alternative Payment Model (APM) participation requirements, and enact several long-sought Medicare Physician Fee Schedule (PFS) budget neutrality reforms. Many provisions reflect policy priorities that physician organizations have advanced in recent years around payment stability, physician-led quality measurement, and value-based payment participation.

Title I: Strengthening Reimbursement and Patient Access

Section 101. Medicare Physician Payment Updates

Beginning in 2027, the bill would replace the current physician payment update structure with a formula tied to the Medicare Economic Index (MEI).

Under the bill:

- The annual update for non-APM clinicians would equal the projected annual increase in MEI minus one percentage point.
- The update could not be less than 25% of MEI growth or greater than 75% of MEI growth.
- Qualifying APM participants would receive the non-APM update plus an additional 0.5 percentage points.

The Secretary would also be required to report annually to Congress on the impact of these payment updates on beneficiary access to services and physician practice consolidation.

Section 102. Hybrid Primary Care Payment Model

The bill would establish a voluntary primary care payment model from 2027 through 2031 under which participating primary care clinicians would receive risk-adjusted monthly payments for attributed beneficiaries in lieu of traditional fee-for-service payments for designated primary care services. Covered services would include:

- Evaluation and management visits;
- Care management services;
- Behavioral health integration services; and
- Patient communications through telephone, email, and patient portals.

The model would eliminate beneficiary cost-sharing on these monthly payments and would be limited to qualifying physician-led primary care practices. Practices meeting certain corporate ownership and control thresholds would be excluded, although practices with 15 or fewer practitioners would be exempt from those restrictions.

Section 103. Geographic Adjustment Changes

For 2027 through 2032, the bill would increase work geographic practice cost indices during "high inflationary years," defined as years in which CPI-U growth exceeds 2 percent. Certain localities would receive an enhanced geographic floor or upward adjustment to physician work values during those years. The legislation also directs the Government Accountability Office to study factors influencing physician practice location decisions.

Title II: MIPS and Quality Measurement Reform

Renaming MIPS as "POINTS"

Beginning in 2032, the Merit-based Incentive Payment System (MIPS) would be renamed the *Patient Outcome Improvement National Tabulation System (POINTS)*. The bill would preserve the underlying structure of the program while implementing several substantive reforms.

Quality and Care Efficiency Reforms

The legislation would:

- Create a new "Care Efficiency" performance category beginning in 2032.
- Increase emphasis on quality performance and resource use.
- Eliminate the current Improvement Activities and Promoting Interoperability categories beginning in 2032.
- Incorporate measures focused on avoidable hospitalizations, chronic disease complications, medication burden, and referral patterns to clinically appropriate lower-cost settings.

Quality Reform Task Force

The bill would establish a physician-led Quality Reform Task Force responsible for developing recommendations on quality, resource use, and care efficiency measures used in the Medicare performance program.

Key provisions include:

- Majority clinician representation.
- Specialty-specific representation requirements.
- Limited payer representation.
- Formal CMS responses to recommendations.
- Enhanced consideration of specialty society guidance and qualified clinical data registry measures.

MIPS Payment Adjustments

The bill would significantly modify MIPS payment adjustment factors.

Maximum negative payment adjustments would be:

- 2% from 2027 through 2031;
- 3% in 2032;
- 4% in 2033; and
- 5% in 2034.

The current 9% maximum penalty would effectively be reduced beginning in 2027.

The bill would also require CMS to provide more detailed claims-based performance feedback and would prohibit negative payment adjustments when CMS fails to provide required performance information.

Qualified Clinical Data Registries (QCDRs)

The legislation would strengthen QCDR requirements beginning in 2027, including standards related to data quality, measure transparency, self-auditing, and practitioner feedback. QCDR approvals would move to renewable three-year certification periods. The bill would also expand registry access to Medicare claims data for research and quality improvement activities.

Appropriate Use Criteria (AUC) Program

The bill would substantially revise implementation of the Appropriate Use Criteria program for advanced imaging by:

- Expanding exemptions for clinical trials, small practices, rural practices, mammography, lung cancer screening, colonography, and emergency services.
- Creating a "low-compliant ordering professional" framework.
- Directing CMS to study future compliance mechanisms, including potential prior authorization approaches for persistently noncompliant providers.

Title III: Alternative Payment Model (APM) Improvements

The bill would freeze current Qualifying APM Participant thresholds through 2029 and 2030 and authorize CMS to establish lower thresholds where appropriate. It would also require Medicare Innovation Center model expansions and early terminations to proceed through notice-and-comment rulemaking and require additional reporting on savings generated by Innovation Center models. Finally, the Government Accountability Office would be directed to study barriers specialty providers face when participating in value-based payment arrangements.

Title IV: Medicare Physician Fee Schedule Reforms

The legislation incorporates several physician fee schedule changes that have been the focus of recent physician payment reform efforts.

Budget Neutrality Threshold

The bill would increase the budget neutrality threshold from \$20 million to approximately \$57.6 million beginning in 2028 and index the threshold to physician practice cost inflation every five years beginning in 2033.

Utilization Reconciliation

CMS would be required to reconcile certain budget neutrality adjustments when actual service utilization differs substantially from estimated utilization assumptions used to set payment rates.

Practice Expense Updates

The Secretary would be required to update practice expense inputs, including clinical staff wages, supply costs, and equipment costs, at least every five years, with all categories updated simultaneously following consultation with physician specialty societies and other stakeholders.

Limitation on Conversion Factor Variance

Beginning in 2027, CMS could not implement budget neutrality adjustments that would cause the conversion factor to fluctuate by more than 2.5 percent from one year to the next, while preserving overall budget neutrality requirements.

Key Takeaway

The Patients First Act of 2026 represents one of the most comprehensive physician payment reform proposals introduced in recent years. The legislation combines near-term physician payment stabilization policies with broader structural reforms to MIPS, quality measurement, primary care payment, APM participation, and Medicare budget neutrality rules. Collectively, the bill seeks to increase payment predictability, strengthen physician-led quality measurement, expand value-based care participation, and address long-standing concerns regarding Medicare physician reimbursement.