

119TH CONGRESS
2D SESSION

S. 5269

To provide for the establishment of hybrid primary care payments under the Medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

AUGUST 5, 2026

Mr. WHITEHOUSE (for himself and Mr. CASSIDY) introduced the following bill;
which was read twice and referred to the Committee on Finance

A BILL

To provide for the establishment of hybrid primary care payments under the Medicare program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Pay PCPs Act of
5 2026”.

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:

8 (1) Transformation of primary care practices
9 serves as an essential foundation for improving
10 health and life outcomes for Medicare beneficiaries,

1 particularly for those with multiple chronic condi-
2 tions and complex needs, mental health challenges,
3 or living in rural and other socioeconomically chal-
4 lenged communities.

5 (2) Research has shown that 25 percent or
6 more of primary care activities are not recognized
7 for payment under most fee schedules, including the
8 Medicare physician fee schedule, largely because
9 these activities reflect a wide range of high fre-
10 quency, brief activities that cannot efficiently be paid
11 fee-for-service and because the billing costs for sub-
12 mitting claims for such services would usually exceed
13 the value of payment.

14 (3) Fee-for-service is ill-suited to support many
15 elements of practice transformation to produce effec-
16 tive primary care, such as developing and maintain-
17 ing multi-disciplinary team-based care strategies
18 that leverage clinicians such as nurse practitioners,
19 physician assistants, nutritionists, and pharmacists,
20 and coordinating care with other clinicians and so-
21 cial service providers.

22 (4) Research has shown that primary care rep-
23 resents a much smaller percentage of total health
24 care spending by payers, regardless of type of insur-
25 ance coverage, in the United States than in other

1 wealthy nations, and that higher percentage of total
2 spending that is devoted to primary care services is
3 associated with lower overall health care spending,
4 and in the Medicare Shared Savings Program, with
5 higher savings performance by accountable care or-
6 ganizations led by physician groups.

7 (5) A composite, prospective payment would
8 provide primary care practices with more predictable
9 and flexible revenues to support such elements of ef-
10 fective primary care and help appropriately value
11 services and activities performed by primary care
12 providers and critical services not currently paid for.

13 (6) Payments for some physician services under
14 the Medicare program, including many that produce
15 substantial spending under the Medicare program,
16 have major distortions.

17 (7) Determination of payments for physician
18 services under the Medicare program currently be-
19 gins with subjective survey-based estimates of clini-
20 cian time and effort per discrete service. This ap-
21 proach to valuing physician services is inconsistent
22 with the comprehensive and continuous nature of
23 primary care.

24 (8) Studies have found that payment levels in
25 the Medicare physician fee schedule reflect estimates

1 of clinician time per service for a variety of services
 2 that are particularly inaccurate.

3 (9) The extreme complexity of having more
 4 than 8,000 billing codes in the Medicare physician
 5 fee schedule risks inaccuracy in estimations of rel-
 6 ative values for closely related procedures and ob-
 7 scures distortions in pricing that grow over time for
 8 specific services.

9 **SEC. 3. ESTABLISHING HYBRID PRIMARY CARE PAYMENT**
 10 **IN MEDICARE.**

11 (a) ESTABLISHMENT.—The Secretary of Health and
 12 Human Services (in this section referred to as the “Sec-
 13 retary”) may establish within the Medicare physician fee
 14 schedule established under section 1848(b) of the Social
 15 Security Act (42 U.S.C. 1395w–4(b)), hybrid payments
 16 only to be available to primary care providers (as defined
 17 in subsection (g)).

18 (b) HYBRID PAYMENTS.—

19 (1) IN GENERAL.—Such hybrid payments may
 20 be comprised of the sum of—

21 (A) prospective, per-member-per-month
 22 payments; and

23 (B) fee-for-service payments.

24 (2) DETERMINATION OF AMOUNT OF PROSPEC-
 25 TIVE, PER-MEMBER-PER-MONTH PAYMENT.—

1 (A) IN GENERAL.—Subject to the pre-
2 ceding provisions of this subsection, the total
3 prospective, per-member-per-month payment—

4 (i) may represent between 40 and 70
5 percent of expected annual total allowed
6 charges derived from the Medicare physi-
7 cian fee schedule for primary care pro-
8 viders of services and suppliers;

9 (ii) should exceed the historic actuari-
10 ally equivalent to the applicable physician
11 fee schedule amounts for the services in-
12 cluded within the total prospective, per-
13 member-per-month payment;

14 (iii) should be calculated based on his-
15 toric Medicare payments for those services
16 which would be included as part of the pro-
17 spective, per-member-per-month payment;
18 and

19 (iv) should support practice trans-
20 formation, expanded care coordination ca-
21 pacity, multidisciplinary team-based care,
22 and services and activities not historically
23 recognized for separate payment under the
24 physician fee schedule, such as communica-
25 tions with patients and their caregivers in-

cluding emails, phone calls, and communications through patient portals.

(B) APPLICATION OF CERTAIN FACTORS.—

The Secretary may consider applying percentages different from those specified in subparagraph (A) for different types of primary care providers based on factors such as historical fee-for-service revenue patterns or quality performance of the provider.

(C) RISK ADJUSTMENT.—The Secretary

may assess the need to risk adjust the prospective, per-member-per-month payment and develop appropriate risk adjustment methodologies, taking into consideration factors that predict levels of primary care service utilization. Risk adjustment methodologies may incorporate clinical diagnoses, demographic factors, and other relevant information such as social determinants of health.

(c) CATEGORIZATION OF SERVICES.—

(1) IN GENERAL.—For such hybrid payments,

the Secretary may create categories of different services that are wholly reimbursed under the Medicare physician fee schedule, but may not include services for which reimbursement occurs partly through

1 other payment schedules under the Medicare pro-
2 gram.

3 (2) SERVICES INCLUDED IN PROSPECTIVE, PER-
4 MEMBER-PER-MONTH PAYMENT.—The Secretary
5 may include the following types of services in the
6 prospective, per-member-per-month payment under
7 this section:

8 (A) Care management services.

9 (B) Communications with patients and
10 their caregivers, such as emails, phone calls,
11 and communications through patient portals.

12 (C) Behavioral health integration services.

13 (D) Office-based evaluation and manage-
14 ment visits, regardless of modality, for new and
15 established patients.

16 (3) CLARIFICATION REGARDING FEE-FOR-SERV-
17 ICE PAYMENT FOR OTHER SERVICES.—For such hy-
18 brid payments, the Secretary may continue to pay
19 through fee-for-service payments for all other serv-
20 ices not specified in paragraph (2) under the Medi-
21 care physician fee schedule, including screenings, ad-
22 ditional preventive services (as defined in section
23 1861(ddd)(1)), annual wellness visits (as defined in
24 section 1861(hhh) of the Social Security Act (42
25 U.S.C. 1395x(hhh))), vaccinations, and initial pre-

1 ventive physical examinations (as defined in section
2 1861(w) of such Act (42 U.S.C. 1395x(w))). The
3 Secretary shall ensure that the services described in
4 the preceding sentence remain separately payable
5 under the Medicare physician fee schedule and the
6 proportion of the payments represented by these
7 services will be not less than the Medicare payments
8 for these services.

9 (d) IDENTIFICATION OF QUALITY MEASURES.—The
10 Secretary may identify quality measures with respect to
11 primary care providers that receive hybrid payment under
12 this section to safeguard health outcomes for Medicare
13 beneficiaries, and reward high quality performance
14 through mechanisms such as annual bonus payments.
15 Quality measures may be identified using existing mecha-
16 nisms such as those approved for use in the Accountable
17 Care Organization/Patient-Centered Medical Home/Pri-
18 mary Care Core Set agreed to by members of the Core
19 Quality Measure Collaborative. Measurement may address
20 areas such as—

- 21 (1) patient experience;
- 22 (2) clinical quality measures;
- 23 (3) service utilization, including measures of
24 rates of emergency department visits and hos-
25 pitalizations; and

1 (4) efficiency in referrals, which may include
 2 measures of the comprehensiveness of services that
 3 the primary care provider furnishes.

4 (e) **ATTRIBUTION.**—The Secretary shall establish
 5 procedures under which a beneficiary is attributed to a
 6 primary care provider using historical claims data and the
 7 beneficiary affirms that the provider is their primary care
 8 provider.

9 (f) **EXCLUSION FROM MIPS.**—Section
 10 1848(q)(1)(C)(ii) of the Social Security Act (42 U.S.C.
 11 1395w–4(q)(1)(C)(ii)) is amended—

12 (1) in subclause (II), by striking “or” at the
 13 end;

14 (2) in subclause (III), by striking the period at
 15 the end and inserting “; or”; and

16 (3) by adding at the end the following new sub-
 17 clause:

18 “(IV) is a primary care provider
 19 that receives hybrid payments pursu-
 20 ant to section 3 of the Pay PCPs Act
 21 of 2026.”.

22 (g) **PRIMARY CARE PROVIDER DEFINED.**—In this
 23 section, the term “primary care provider” means a practi-
 24 tioner (as defined in section 1842(b)(18)(C)) of such Act
 25 (42 U.S.C. 1395u(b)(18)(C)) or a physician (as defined

1 in section 1861(r)) of the Social Security Act (42 U.S.C.
 2 1395x(r)) who furnishes primary care services (as defined
 3 in section 1842(i)(4)) of such Act (42 U.S.C.
 4 1395u(i)(4)).

5 (h) APPROPRIATION.—

6 (1) IN GENERAL.—In addition to other
 7 amounts made available, for purposes of making hy-
 8 brid payments under this section, there is appro-
 9 priated to the Secretary, out of any moneys in the
 10 Treasury not otherwise appropriated,
 11 \$10,000,000,000 for fiscal years 2027 through
 12 2031.

13 (2) BUDGET NEUTRALITY WAIVER.—The
 14 amounts made available under paragraph (1) shall
 15 not be taken into account in applying section
 16 1848(c)(2)(B)(ii)(II) of the Social Security Act (42
 17 U.S.C. 1395w-4(c)(2)(B)(ii)(II)).

18 (i) RULE OF CONSTRUCTION.—Nothing in this sec-
 19 tion shall be construed to require a primary care provider
 20 to receive hybrid payments established under this section.

21 **SEC. 4. REDUCING BENEFICIARY COST SHARING FOR PRI-**
 22 **MARY CARE SERVICES.**

23 (a) IN GENERAL.—Notwithstanding any other provi-
 24 sion of law, the Secretary of Health and Human Services
 25 (in this section referred to as the “Secretary”) may reduce

1 by 50 percent any beneficiary cost sharing otherwise appli-
2 cable under part B of title XVIII of the Social Security
3 Act (42 U.S.C. 1395j et seq.) for primary care services
4 that are reimbursed through the hybrid payments estab-
5 lished under section 3, provided that the beneficiary des-
6 ignates a primary care provider as their usual source of
7 care and informs the Secretary of who that provider is
8 pursuant to the procedures established under section 3(e).

9 (b) REPORT TO CONGRESS.—Not later than 180 days
10 after the date on which subsection (a) is first imple-
11 mented, and annually thereafter, the Secretary shall sub-
12 mit to Congress a report on the implementation of such
13 subsection, including an analysis of—

14 (1) whether the reduction of beneficiary cost-
15 sharing under such subsection has impacted bene-
16 ficiary utilization of primary care services that may
17 be reimbursed through the newly established per-
18 member-per-month payment; and

19 (2) whether the Secretary has observed any in-
20 stances of fraud or abuse associated with the reduc-
21 tion of such cost-sharing, and whether the Secretary
22 has taken steps to minimize any such fraud or
23 abuse.

1 **SEC. 5. ESTABLISHING A NEW TECHNICAL ADVISORY COM-**
 2 **MITTEE ON RELATIVE VALUE UPDATES AND**
 3 **REVISIONS.**

4 Section 1848(c)(2) of the Social Security Act (42
 5 U.S.C. 1395w-4(c)(2)) is amended by adding at the end
 6 the following new subparagraph:

7 “(P) ESTABLISHMENT OF TECHNICAL AD-
 8 VISORY COMMITTEE ON RELATIVE VALUE UP-
 9 DATES AND REVISIONS.—

10 “(i) IN GENERAL.—The Secretary
 11 shall establish a technical advisory com-
 12 mittee (in this section referred to as the
 13 ‘committee’) within the Centers for Medi-
 14 care & Medicaid Services to provide the
 15 Secretary with technical input regarding
 16 the accurate determination of relative value
 17 units under this paragraph.

18 “(ii) MEMBERSHIP.—

19 “(I) IN GENERAL.—The com-
 20 mittee shall be composed of 13 mem-
 21 bers appointed by the Secretary from
 22 among individuals—

23 “(aa) reflecting diverse expe-
 24 riences in provider payment, in-
 25 cluding providers billing the
 26 Medicare program under this

1 title, providers providing care
2 under the laws administered by
3 the Secretary of Veterans Affairs
4 or the Secretary of Defense, and
5 primary care providers (as de-
6 fined in subclause (III)); and

7 “(bb) with technical exper-
8 tise in Medicare payment policies.

9 “(II) CHAIR.—1 of the members
10 appointed under subclause (I) shall be
11 a representative of personnel of the
12 Centers for Medicare & Medicaid
13 Services, and that member shall serve
14 as chair of the committee.

15 “(III) PRIMARY CARE PRO-
16 VIDER.—For purposes of this clause,
17 the term ‘primary care provider’
18 means a practitioner (as defined in
19 section 1842(b)(18)(C)) or a physi-
20 cian (as defined in section 1861(r))
21 who furnishes primary care services
22 (as defined in section 1842(i)(4)).

23 “(iii) STAFF.—The committee shall be
24 staffed by personnel of the Centers for
25 Medicare & Medicaid Services.

1 “(iv) DUTIES.—The committee shall
2 advise the Secretary on an ongoing basis
3 regarding the determination of relative
4 value units under the physician fee sched-
5 ule through duties such as the following:

6 “(I) Designing new valuation
7 methodologies the Secretary may use
8 to determine the time and resources
9 use by health professionals associated
10 with furnishing services or other new
11 approaches to determining relative re-
12 sources for each HCPCS code. The
13 committee may prioritize furnished
14 services that are most common or rep-
15 resent the services with the highest al-
16 lowed charges.

17 “(II) Advising on research and
18 development relevant to the deter-
19 mination of relative value units for in-
20 dividual HCPCS codes.

21 “(III) Providing recommenda-
22 tions with respect to changes in valu-
23 ations of current HCPCS codes based
24 upon any newly developed valuation
25 methodologies.

1 “(IV) Evaluating whether exist-
2 ing HCPCS codes within the same
3 family of services should be collapsed
4 to result in fewer payment codes.

5 “(V) Identifying opportunities for
6 bundling or unbundling services for
7 payment purposes.

8 “(VI) Assessing the operational
9 burden of new approaches on physi-
10 cians and other suppliers and bene-
11 ficiaries while also considering the
12 vulnerabilities of new approaches on
13 overt fraud and abuse.

14 “(VII) Assessing the impacts of
15 these new approaches and potential
16 adoption on beneficiary access, finan-
17 cial liabilities, quality of care, and
18 health disparities.

19 “(v) FUNDING.—

20 “(I) IMPLEMENTATION.—The
21 Secretary may provide for the trans-
22 fer, from the Federal Supplementary
23 Medical Insurance Trust Fund under
24 section 1841, such amounts as are
25 necessary to carry out this subsection

(other than research and development under clause (iv)(II)) (not to exceed \$5,000,000) for each of fiscal years 2027 through 2031. Any amounts transferred under the preceding sentence for a fiscal year shall remain available until expended.

“(II) RESEARCH AND DEVELOPMENT.—The Secretary may provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, such amounts as are necessary to carry out research and development under clause (iv)(II) (not to exceed \$10,000,000) for each of fiscal years 2027 through 2031. Any amounts transferred under the preceding sentence for a fiscal year shall remain available until expended.

“(vi) DURATION.—The committee shall terminate not later than the expiration of the 5-year period beginning on the date of its establishment.”.

