Statement for the Record of Heart Rhythm Advocates
House Committee on Energy and Commerce
Subcommittee on Health
Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity
September 15 2026

Chairman Griffith, Ranking Member DeGette, and members of the Subcommittee:
Heart Rhythm Advocates appreciates the opportunity to submit this statement for the record regarding the legislative proposals before the Subcommittee. Heart Rhythm Advocates represents physicians and other healthcare professionals who diagnose and treat heart-rhythm disorders, including atrial fibrillation, ventricular arrhythmias, inherited rhythm disorders, and conditions that can result in stroke, heart failure, or sudden cardiac death. Cardiac electrophysiology combines longitudinal medical management, advanced diagnostic services, complex procedures, implanted cardiac devices, and continuous remote monitoring. Delivering this care requires multidisciplinary clinical teams, sophisticated technology, substantial infrastructure, and sustained investment in professional expertise. The proposals on the hearing docket could affect electrophysiology through Medicare payment stability, budget neutrality, quality reporting, practice-expense valuation, site of service, access to claims data, advanced diagnostic imaging, remote monitoring, and healthcare cybersecurity.

Summary of recommendations

- Advance H.R. 9693 and H.R. 8163, whether individually or as components of the next viable Medicare legislative package.
- Protect independent, small, rural, and specialty practices in any replacement for the Merit-based Incentive Payment System.
- Require specialty-appropriate measures, reliable attribution, transparent data, and prospective testing before performance-based payment adjustments apply.
- Ensure that any expansion of office-based procedural care is clinically appropriate and subject to consistent safety, accreditation, and emergency-preparedness standards.
- Avoid reactivating imaging requirements that recreate prior authorization, impose unnecessary administrative burden, or delay time-sensitive cardiac care.
- Preserve access to clinically appropriate remote monitoring and provide practical cybersecurity support to smaller and rural providers.

The need for structural Medicare physician payment reform

Medicare's physician-payment system does not provide the stability necessary to sustain access to specialty care. Practice costs (including clinical staffing, equipment, rent, cybersecurity, regulatory compliance, and information technology) continue to increase while Medicare payment updates have repeatedly failed to reflect those costs.

Congress has frequently responded to scheduled payment reductions with temporary relief. Although these interventions have prevented deeper immediate cuts, they have not corrected the structural problems that produce instability year after year. That instability is especially

challenging for independent and community-based practices. It can delay hiring, discourage investment in technology, and accelerate consolidation into larger hospital systems. In rural and underserved areas, the loss of a specialty practice may force patients to travel considerable distances for care.

For electrophysiology patients, delayed access can have serious consequences. Delays in evaluation, diagnostic testing, device management, or procedures can increase the risk of stroke, heart failure, hospitalization, syncope, or sudden cardiac death. Medicare payment policy should support timely intervention, longitudinal management, and the infrastructure required to monitor high-risk patients between visits.

H.R. 9693 Patients First Act of 2026

Heart Rhythm Advocates strongly supports the central reforms in H.R. 9693. Beginning in 2027, the bill would establish an annual update to the nonqualifying alternative payment model conversion factor equal to the Secretary's estimated increase in the Medicare Economic Index minus one percentage point, subject to a floor and ceiling tied to the MEI. The qualifying APM conversion-factor update would be 0.5 percentage point higher. This approach would create a more predictable relationship between Medicare payment and the cost of operating a medical practice than the current cycle of scheduled reductions and short-term congressional interventions.

Predictable updates would help practices make responsible decisions about clinical staffing, equipment, technology, and patient services. They would also help preserve independent practices and maintain access in communities where specialist availability is already limited. The bill would also modernize Medicare's budget-neutrality policies. The existing threshold has not kept pace with the size or complexity of the physician fee schedule. As a result, recognition of new services or correction of previously undervalued services can produce reductions affecting physicians throughout the system. Budget neutrality should not force specialties to compete against one another whenever Medicare recognizes innovation or updates a service. A higher, indexed threshold and improved safeguards would reduce unnecessary volatility while preserving appropriate fiscal accountability.

H.R. 9693 would further transition MIPS into the Patient Outcome Improvement National Tabulation System, or POINTS. HRA supports meaningful quality measurement and accountability, but measures must reflect clinical outcomes, recognize specialty care, and provide actionable information. The development and implementation of POINTS should include meaningful input from practicing physicians, specialty societies, qualified clinical data registries, and patients. Electrophysiologists should not be evaluated using measures that do not accurately reflect the patients they treat or the services they furnish.
We understand H.R. 9693 is comprehensive and may be difficult to enact as a stand-alone measure. We nevertheless urge the Subcommittee to use its principal provisions as a framework for reform and to incorporate them into the next viable Medicare legislative package if the bill cannot advance independently.

H.R. 8163 Provider Reimbursement Stability Act of 2026

Heart Rhythm Advocates also strongly supports H.R. 8163. The bill would increase the dollar threshold that triggers a budget-neutrality adjustment, index that threshold for future years, improve the information available to CMS and stakeholders when utilization differs from projections, and phase in certain significant payment reductions over two years.

A medical practice should not first learn about a consequential payment reduction only months before it takes effect. Earlier and more transparent information would allow physicians, professional societies, and policymakers to identify errors, evaluate specialty-level effects, and propose appropriate corrections. Comparing projected utilization with actual utilization would also improve the accuracy and credibility of the budget-neutrality process.

Phasing in large adjustments would protect patient access. A sudden reduction can force a practice to defer hiring, discontinue a service, or reconsider whether it can continue accepting Medicare patients. Gradual implementation allows practices to adapt without abrupt disruption. H.R. 8163 would not resolve every weakness in Medicare physician payment, but it would reduce volatility and provide practical near-term protection while Congress considers broader reform. We urge the Subcommittee to advance it alongside the structural reforms in H.R. 9693.

H.R. 8622 Medicare Physician Data Driven Performance Payment System Act of 2026
H.R. 8622 would replace MIPS with a Data-driven Performance Payment System that relies more heavily on claims-based measures and provides participating clinicians with quarterly performance information. HRA agrees that MIPS requires fundamental reform. More timely feedback and reduced reliance on clinician-reported data could lower administrative burden and make performance information more useful.

Several elements require careful review. Claims can establish that a service occurred, but they often cannot show clinical appropriateness, disease severity, patient preference, procedural complexity, or why a particular treatment was selected. Claims-only measurement may therefore produce misleading comparisons among electrophysiologists treating different patient populations.

Patient attribution presents a related concern. Electrophysiologists frequently participate in the care of patients with multiple cardiovascular and noncardiovascular conditions. A specialist should not be held responsible for costs or outcomes primarily attributable to care furnished by other clinicians or to conditions beyond the specialist's reasonable control. The proposal's payment multipliers make measurement accuracy especially important. Beginning with 2028, the bill contemplates an adjustment factor of 1.25 for performance above the applicable threshold, 1.0 at the threshold, 0.75 below the threshold, and 0.5 for nonreporting clinicians. Before adjustments of that magnitude apply, CMS should validate the measures, attribution methods, benchmarks, risk adjustment, and underlying data for each affected specialty. Clinicians should have a meaningful opportunity to review and correct data before payment consequences attach.

We appreciate the bill's recognition of practices with 15 or fewer eligible professionals. Congress should consider additional protections for rural practices, shortage-area physicians, and specialties for which sufficiently reliable claims-based measures do not exist. Any replacement for MIPS should be developed with practicing physicians and specialty societies, tested before financial consequences apply, and designed to reward meaningful improvement rather than documentation or coding proficiency.

H.R. 7863 Promoting Fairness for Medicare Providers Act of 2026

H.R. 7863 would establish a Medicare facility payment for certain high-supply-cost surgical procedures performed in an office-based facility that meets specified conditions. In general, the payment would equal 90 percent of the ambulatory surgical center facility amount for an eligible procedure, with a separate methodology for device-intensive procedures.

The proposal could affect certain device-intensive or high-supply-cost cardiovascular services. Its application to electrophysiology is uncertain, however, because the bill does not identify qualifying codes and generally relies on historical criteria, including whether a procedure was payable in both the office and ASC settings during the statutory reference year. Congress and CMS should identify the eligible procedures publicly and analyze specialty-specific effects before implementation.

Electrophysiology procedures vary substantially in complexity and patient risk. Some patients may be appropriate candidates for care outside a hospital; others require hospital resources. Payment policy should not encourage a patient to receive care in a setting that is not clinically appropriate. Any participating office-based facility should meet rigorous and consistent requirements for accreditation, infection control, anesthesia, emergency response, patient selection, transfer agreements, staffing, and outcomes reporting.

Congress should also consider how historical supply-cost and site-of-service data will account for rapidly changing technology. HRA supports expanding access to clinically appropriate sites of care, but recommends further technical review of eligible procedures, payment methodology, patient-selection criteria, and safety standards before enactment or implementation.

H.R. 4331 Access to Claims Data Act

H.R. 4331 would expand access to Medicare, Medicaid, and Children's Health Insurance Program claims data for qualified clinical data registries and clinician-led registries conducting research and quality-improvement activities. HRA supports the objective of giving qualified registries appropriate access to longitudinal claims information, subject to strong privacy and security safeguards.

Clinical registries help measure outcomes, identify variations in care, and improve the safety and effectiveness of cardiovascular treatment. Linking clinical information with claims data can provide a more complete understanding of arrhythmia care, implanted-device outcomes, repeat procedures, hospitalizations, stroke, heart failure, healthcare utilization, and disparities in access.

Fees should be reasonable and should not prevent nonprofit or specialty-led registries from participating. CMS should provide information in a timely, standardized, and usable form. The bill's January 1, 2026 deadline for establishing the data-access process has already passed. The Subcommittee should update that date and provide CMS a realistic implementation period before advancing the legislation.

H.R. 5737 Radiology Outpatient Ordering Transmission Act

H.R. 5737 would reactivate and restructure Medicare's appropriate-use-criteria program for advanced diagnostic imaging. HRA supports evidence-based imaging. Cardiac CT, MRI, and nuclear imaging can be important in arrhythmia diagnosis, procedural planning, and evaluation of structural or ischemic heart disease. We are concerned, however, that the legislation could restore a burdensome administrative system without demonstrating a corresponding improvement in patient care.

The bill would shift transmission of required ordering information from claims to qualified clinical decision-support mechanisms, identify clinicians considered low compliant, and direct CMS to study potential enforcement mechanisms, including prior authorization or payment adjustments. These policies could add administrative steps and delay diagnosis. Prior authorization would be especially concerning given the burdens patients and physicians already encounter under commercial and Medicare Advantage utilization-management programs.

If Congress proceeds, it should exempt emergency and time-sensitive care, require relevant specialty-society participation in the development of criteria, establish a clear appeals and correction process, and prohibit automatic prior-authorization or payment penalties without further congressional action. CMS should demonstrate measurable improvement in appropriateness, outcomes, or program integrity before financial consequences are imposed.

The bill also uses a January 1, 2026 effective date that has already passed. The Subcommittee should correct the date and allow adequate time for technical implementation, clinician education, testing, and evaluation.

Health Care Cybersecurity and Resiliency Act of 2026 discussion draft

The unnumbered discussion draft would strengthen coordination between the Department of Health and Human Services and the Cybersecurity and Infrastructure Security Agency and expand federal support for healthcare-sector cybersecurity. Cybersecurity is a patient-safety issue for electrophysiology. Practices rely on electronic health records, remote-monitoring platforms, connected medical technology, and the secure transmission of information from implanted cardiac devices. A cyberattack can disrupt scheduling, prevent access to clinical information, interrupt remote-monitoring workflows, and delay medically necessary care. HRA encourages stronger federal coordination, timely threat information, and practical technical assistance. Policymakers should recognize that small and independent practices often lack the cybersecurity resources available to large health systems. Any new federal expectations should therefore be risk-based and accompanied by financial and technical support. Policy should also reflect the shared responsibilities of healthcare providers, device

manufacturers, technology vendors, clearinghouses, and other business associates. Unfunded mandates could inadvertently accelerate consolidation or cause smaller practices to abandon beneficial technology.

H.R. 9908 Rural Hospital Cybersecurity Enhancement Act
H.R. 9908 would support development of the cybersecurity workforce needed by rural hospitals. Rural hospitals serve as critical access points for patients requiring emergency stabilization, cardiovascular evaluation, and referral to electrophysiology specialists. Cyberattacks affecting these facilities can disrupt care across an entire region.

Targeted assistance can help rural providers recruit personnel, obtain technical expertise, and maintain secure clinical systems. Assistance should account for the connected networks through which rural hospitals communicate with specialty practices, remote-monitoring providers, and larger referral centers. Congress should also consider comparable technical support for rural physician practices and other small healthcare organizations. HRA offers these observations without taking a formal position on the bill.

Conclusion
HRA urges the Subcommittee to advance the central reforms in H.R. 9693 and H.R. 8163; ensure that any replacement for MIPS uses validated, specialty-appropriate measures and fair attribution; require strong safety protections in any expansion of office-based procedural care; expand appropriate access to claims data for physician-led quality improvement; avoid imaging requirements that recreate prior authorization or unnecessary administrative burden; protect access to clinically appropriate remote monitoring; and provide healthcare practices with the resources necessary to address evolving cybersecurity threats.

We recognize that comprehensive Medicare physician-payment reform may ultimately advance through a broader legislative package rather than as a single stand-alone bill. This hearing is an important opportunity to identify areas of bipartisan agreement and prepare durable reforms for the next viable Medicare vehicle.

Heart Rhythm Advocates appreciates the Subcommittee's attention to these issues and looks forward to serving as a resource as this work continues.