CAFM Supported Legislation

119th Congress (2025–2026)

S. 5269 Pay PCPs Act of 2026

Sponsors: Sen. Sheldon Whitehouse (D-RI) and Sen. Bill Cassidy (R-LA)

Authorizes HHS to establish a hybrid Medicare primary care payment model combining a prospective per-member-per-month (PMPM) payment with fee-for-service. The PMPM portion could represent roughly 40 to 70% of expected annual Medicare primary care charges, is risk-adjusted for clinical and social factors, and is meant to fund care coordination, team-based care, and other traditionally unpaid work. Preventive services, wellness visits, and vaccinations stay separately payable outside the bundle. The bill appropriates $10 billion for FY2027 through FY2031, exempts that funding from Medicare Physician Fee Schedule budget-neutrality rules, and allows HHS to cut Medicare Part B beneficiary cost sharing by 50% for primary care services delivered through the model. It also creates a 13-member CMS technical advisory committee to study how relative value units are calculated. Participation is voluntary.

Why it matters for academic family medicine: *Represents one of the largest proposed federal investments in primary care payment reform to date. A hybrid PMPM option, with participation voluntary and separate from MIPS, offers family medicine practices, including rural ones, a payment path less dependent on fee-for-service volume.*

H.R. 9693 Patients First Act of 2026

Sponsors: Reps. John Joyce (R-PA)

A bipartisan overhaul of Medicare physician payment. The bill applies inflation-based updates to the Medicare Physician Fee Schedule conversion factor, establishes a hybrid PMPM payment demonstration project for primary care without added patient cost sharing, and reforms MIPS quality reporting through a new framework (Title II, the Patient Outcome Improvement National Tabulation System, or POINTS) built around clinician-led clinical data registries. It is aimed at the payment instability that has driven independent practice consolidation, particularly in rural and underserved areas.

Why it matters for academic family medicine: *Complements the Pay PCPs Act's hybrid payment model with broader fee-schedule stability reforms; addresses the payment volatility that has made it difficult to sustain independent, rural-based family medicine practices.*

H.R. 7961 H-1Bs for Physicians and the Healthcare Workforce Act

Sponsors: Reps. Mike Lawler (R-NY) and Sanford Bishop (D-GA)

Would exempt physicians and other health care workers, including nurse practitioners, nurses, pharmacists, and dentists, from the $100,000 H-1B petition fee established by a September 2025 presidential proclamation. Employers of visa-holding physicians would return to paying the fee structure in place before that proclamation.

Why it matters for academic family medicine: *Directly addresses the cost barrier facing rural residency programs and hospitals that sponsor international medical graduates, many of whom fill family medicine and other primary care positions in underserved areas.*

S. 3989/ H.R. 3885 Community TEAMS Act of 2026 (Community Training, Education, and Access for Medical Students Act)

Sponsors: Sen. John Curtis (R-UT) and Sen. Angus King (I-ME)

Amends the Public Health Service Act to fund community-based clinical training sites for medical students in rural and medically underserved areas, with a particular focus on Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Currently, roughly 80% of physician training happens in academic medical centers even though students who train in community settings are more likely to practice in them later.

Why it matters for academic family medicine: *Creates new community-based training slots that residency programs and medical schools with rural tracks could draw on, expanding the pipeline upstream of residency, at the medical-student level.*

H.R. 7173 Follow the Science Act

Sponsors: Rep. Diana DeGette (D-CO)

Amends the Public Health Service Act to bar political appointees at HHS, other than the NIH Director, National Cancer Institute Director, and ARPA-H Director, from participating in NIH grant-making, research review, or funding decisions. The bill is framed as a scientific-integrity measure meant to prevent political considerations from influencing which research NIH funds.

Why it matters for academic family medicine: *Relevant to any faculty whose research funding runs through NIH; the bill's scope is broader than rural health specifically, and it has not attracted Republican cosponsors to date.*

H.R. 6804 / S. 3250 Rural Hospital Flexibility Act of 2025

Sponsors: Reps. Carol Miller (R-WV) and Terri Sewell (D-AL); Sens. Maggie Hassan (D-NH) and John Barrasso (R-WY)

Reauthorizes and updates the Medicare Rural Hospital Flexibility (FLEX) grant program, which funds State Offices of Rural Health to support Critical Access Hospitals (CAHs) on quality improvement, financial and operational training, EMS enhancement, and technology upgrades. The bill also revises the funding formula so each state's grant share is tied to its number of eligible small rural hospitals.

Why it matters for academic family medicine: *Strengthens the Critical Access Hospitals that many rural training sites and rotations depend on for clinical placements.*

H.R. 6468 Rural Residency Planning and Development Act of 2025

Sponsors: Rep. Carol Miller (R-WV)

Codifies HRSA's Rural Residency Planning and Development (RRPD) Program directly into the Public Health Service Act, giving it permanent statutory authority rather than relying solely on annual appropriations. The RRPD program funds start-up costs for new rural residency programs, including new rural training tracks added to existing programs. Since 2019, it has supported 46 new accredited rural residency programs across family medicine, internal medicine, psychiatry, and general surgery, creating 575 rural residency positions in 36 states.

Why it matters for academic family medicine: *This is likely the single most directly relevant bill on this list for STFM members. It protects and formalizes the primary federal funding mechanism for starting new rural family medicine residency programs.*

S. 3038 Health Care Workforce Real-Time Data Dashboard Act

Sponsors: Sens. Marsha Blackburn (R-TN) and David McCormick (R-PA)

Directs HRSA to build and maintain a real-time public dashboard tracking graduate medical education (GME) residency positions, including application volumes, geographic distribution of applicants, and interview activity. The bill also requires periodic reports evaluating how effectively federal programs are addressing physician shortages in medically underserved communities.

Why it matters for academic family medicine: *Would give residency programs and workforce stakeholders better real-time visibility into where GME positions and applicants are concentrated, useful context when making the case for new rural training slots.*

H.R. 771 Rural Health Care Access Act of 2025

Sponsors: Rep. Mark Green (R-TN), with Reps. Glenn Thompson (R-PA), Ronny Jackson (R-TX), and Mary Miller (R-IL)

Removes the mileage-based eligibility requirement for Critical Access Hospital (CAH) designation under Medicare. Currently, a facility generally must be located more than 35 miles from another hospital (or 15 miles in mountainous areas or areas with only secondary roads) to qualify, unless it was already certified as a necessary provider before January 1, 2006. This bill would let states designate qualifying rural facilities as CAHs without regard to that distance requirement.

Why it matters for academic family medicine: *Could expand the number of facilities eligible for CAH status, and by extension the number of sites eligible to host rural training rotations and serve as clinical partners for residency programs.*

H.R. 1153 Rural Physician Workforce Production Act of 2025

Sponsors: Reps. Diana Harshbarger (R-TN), Kim Schrier (D-WA), and Don Bacon (R-NE)

Amends Medicare graduate medical education (GME) payment rules to support rural physician training. Hospitals, critical access hospitals, sole community hospitals, and rural emergency hospitals could elect to receive payment for resident time spent training in a rural location, as long as the rotation lasts at least eight weeks and the hospital pays the resident's salary and benefits during that time. It also allows hospitals to receive payment for all resident time in any program where at least 50% of training occurs in rural locations, regardless of specialty or where the rest of the training happens.

Why it matters for academic family medicine: *Directly funds the kind of rural rotations and rural training tracks that family medicine residency programs rely on, addressing a long-standing GME payment gap that has discouraged hospitals from taking on rural-based residents.*