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September 12, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Oz,

The Society of Hospital Medicine (SHM), representing the nation's nearly 50,000 hospitalists, appreciates the opportunity to provide comments on the proposed rule: *Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program* (CMS-1832-P).

Hospitalists are physicians whose professional focus is the general medical care of hospitalized patients. In addition to managing the clinical care of patients, hospitalists work to enhance the performance of their hospitals and health systems. The unique position of hospitalists in the healthcare system affords a distinctive role in facilitating both the individual physician-level and systems- or hospital-level performance agendas.

We offer the following comments on proposals in the rule:

II.B. Determination of PE RVUs

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

CMS proposes to make a significant change to Practice Expense (PE) Relative Value Units (RVUs) for facility-based services and

procedures. Specifically, they propose reducing, by half, input to the formula for all facility PE RVUs based on work RVUs to half the amount allocated to nonfacility PE RVUs. This change, if finalized, would go into effect on January 1, 2026. **SHM strongly opposes this drastic and arbitrary cut to facility PE and urges CMS to work with stakeholders and their lived experience to address concerns around practice expense rather than relying on a hypothesis.**

Table 92 in the rule provides the CY 2026 PFS Estimated Impact on Total Allowed Charges by Specialty. Although hospitalists are not named specifically in this table, the estimated cuts for facility-based Internal Medicine and Family Medicine, who are generally hospitalists, range from -8% to -9%. Some hospital medicine groups have independently estimated an approximately 6.5% cut, which will increase depending on their billing patterns. A cut of this magnitude will have profound impact on the functioning and viability of hospital medicine groups and negatively impact patient care.

In its discussion, CMS cites MedPAC's recent concerns about potential duplicative payments for the indirect costs of care for physicians who practice in the facility setting. The agency highlights the trend of practice ownership structure—that more physician practices are owned by hospitals or health systems. They detail the historical shift from private practice towards hospital-owned practices or direct employment by a hospital. CMS also cites MedPAC's data that there are 9 specialties where 60 percent of the clinicians who billed Medicare furnished 90 percent or more of their services in a facility setting.

The shift towards setting-based specialization is not new—hospitalists have been practicing for decades and are an exemplar of this trend. Hospitalists are typically board certified in internal medicine, family medicine, pediatrics or med-peds and practice exclusively in the hospital setting. However, SHM takes issue with the leap of logic from CMS and MedPAC that there is a significant bolus of overspending or duplicative payment in facility PE. We do not believe CMS has demonstrated actual duplication in spending in its proposals, but rather it has identified a hypothesis that the agency must explore further before proposing any cuts or changes to PE rates.

- *This proposed change will fuel the end of independent facility-based practices.* Independent hospital medicine groups operate around the country, tending to be smaller local or regional groups. These groups are reliant on their billing, certainly

have significant practice expense, and do not have the ability to absorb significant cuts the way a large health system may be able. These cuts may force many of these independent groups to sell their practices to hospitals, health systems, or larger entities. This result runs counter to CMS' stated goals of supporting physician-owned independent practices.

- *There are significant practice expense costs for facility-based physician practices*. CMS acknowledges some specific indirect practice expense costs for facility-based physicians, including coding, billing and scheduling. This list is incomplete and does not reflect the reality or magnitude of practice expenses incurred by facility-based groups. Typical practice expenses include but are not limited to revenue cycle software, clinician education and recruitment, utilization management and denials management, MIPS data collection and submission tools, and purchased services from the health system or facility.

- *PE is already adjusted between facility and non-facility settings*. Although hospitalists typically bill the Hospital Inpatient/Observation Care family of CPT codes that do not have non-facility PE, the PE associated with these codes is already adjusted downwards from comparable office/outpatient codes. For example, CPT code 99223 is the highest severity initial hospital visit E/M code and has a facility PE of 1.39. CPT code 99205, which is the highest severity initial office visit E/M code, has a non-facility PE of 2.83 and a facility PE of 1.59. Both within 99205 and comparing 99205 to 99223, the facility PE is already adjusted to be significantly lower than the non-facility PE. CMS has not demonstrated why the existing difference between facility and non-facility PE values is insufficient or why it fails to address a hypothetical problem CMS is asserting exists.

- *Reducing inputs to the formula for facility PE by half is an arbitrary cut*. CMS has not provided a rationale, supported by data or even anecdotal experience, why reducing facility PE by half is reasonable. Absent from the proposed rule is an analysis of actual PE costs between settings and a demonstration that the costs in the facility setting are truly half of the existing PE rates. Indeed, PE should be assessed per code or code family to ensure accuracy, but this must be done through a systematic process that takes real world practice expenses into account.

- *Direct hospital employment does not eliminate practice expenses*. Practice expense does not go away by virtue of being directly employed by a hospital or health system. Hospitals typically require budgeting at the department or unit level and charge back the physician related PE costs to that department or unit, resulting in reduced compensation. Therefore, the proposal would not account for costs incurred by non-hospital-employed or even hospital-employed physicians who provide services in the facility.

SHM urges CMS not to finalize the proposed cut to facility PE. We instead encourage CMS to work with stakeholders to better understand whether the posited problem with duplicate payments for PE is real. CMS must not enact a cut of this magnitude without quantifying the extent of the problem or considering the impact on independent facility-based physician practices.

II.D. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

CMS proposes to eliminate the frequency limitations for providing subsequent care services in the inpatient and nursing facility settings. These limitations were an arbitrary policy that impeded the adoption of telemedicine in these settings. **SHM strongly supports this proposal and encourages CMS to finalize eliminating the frequency limitations.**

II.L. Strategies for Improving Global Surgery Payment Accuracy

SHM appreciates CMS' efforts to ensure global payment periods accurately reflect the delivery of services during the respective payment period. Much has changed and continues to change in the management of surgical and immediate post-operative patients, including the continued expansion of co-management of patients between hospitalists and specialty service lines in the hospital. We support efforts to ensure clinicians who provide care, both surgical and non-surgical, are being paid for the services they deliver.

IV. Updates to the Quality Payment Program

Transforming the Quality Payment Program

Society of Hospital Medicine

CMS proposes a number of changes relating to transitioning from traditional Merit-based Incentive Payment System (MIPS) to MIPS Value Pathways (MVPs). SHM continues to be wary of CMS' continued drive towards MVPs in light of very limited uptake of existing MVPs, a paucity of available MVPs for clinicians, and a lack of any evidence that MVPs bring significant policy improvements as compared to traditional MIPS. We urge the agency to reconsider whether the push toward MVPs and the time and effort involved in their development are furthering its goals in improving care quality and incentivizing high-quality efficient care for Medicare beneficiaries. Our members commonly indicate the structure of the Quality Payment Program makes the program a compliance exercise, rather than a tool for real quality improvement and the MVP concept does not alter this sentiment. SHM encourages CMS to keep the following points in mind as it thinks about the future of the Quality Payment Program.

SHM estimates more than 50,000 hospitalists practice in hospitals today, which accounts for roughly 5% of the total number of practicing physicians in the country. If CMS used these numbers to determine our specialty, hospitalists would be one of the top 5 largest physician specialties. The only specialties larger are Internal Medicine, Family Medicine and Pediatrics (all three of which count hospitalists within their ranks). We also estimate that hospitalists provide care for more than half of all hospitalized Medicare patients annually. Given the size of the specialty and its integral role in caring for hospitalized patients, we continue to be concerned that current MVP structures and policies are not relevant to the practice of hospital medicine. MVPs, as currently structured, do nothing to address the challenges hospitalists face in deriving useful and actionable data from MIPS participation.

> **SHM continues to oppose the rapid adoption of mandatory MVP reporting because there are no available MVPs for hospitalists and the pathway to develop a relevant MVP for hospitalists is uncertain and quite possibly unattainable.**

CMS should not eliminate traditional MIPS reporting until ALL MIPS eligible clinicians are able to utilize meaningful and actionable MVPs. This should be the determining factor of any decision to sunset the MIPS. We do not view CMS' potential option of a "global MVP with broadly applicable measures" as an alternative for clinicians who do not have an MVP. One-size-fits-all approaches to quality measurement and performance assessment

will lack in meaningful information, further disengage clinicians from the program, and will lead to unnecessary administrative burdens.

Subgroup Reporting

CMS proposes that beginning with the CY 2026 MIPS performance period/2028 MIPS payment year, multispecialty groups will no longer be able to report MVP as a single group. This will mean that if a multispecialty group would like to report an MVP, MIPS eligible clinicians in multispecialty groups must divide into and report as subgroups or report as an individual. Groups would need to attest to the specialty composition of the group during the MVP registration.

SHM supports CMS' proposal to use attestation to determine the composition of subgroups. We appreciate CMS considering our prior comments about how hospital medicine groups are commonly comprised of multiple different specialties and NPs and PAs. Attestation affords groups the ability to identify teams that would reasonably be expected to report on the same MVP. We believe attestation is a better solution for identifying subgroups for the purposes of reporting and does not present the same challenges as claims-based designations for subgroups.

Core Elements Request for Information (RFI)

CMS asserts that one of the goals of the transition from traditional MIPS to MVPs is to provide patients with comparative clinician performance data to make better assessments of the care provided to patients by requiring clinicians within an MVP to report on the same group of measures. CMS is considering a future policy to require an MVP Participant to select one quality measure from a subset of quality measures in each MVP, referred to as "Core Elements." MVP Participants would select the other three required quality measures and would still have to meet existing MVP reporting requirements. This policy aims to emphasize and increase reporting on select quality measures that are most important to clinicians and patients and reflect care that is at the crux of the MVP's applicable specialty, medical condition, or episode of care.

We are concerned a core elements policy may be recreating issues with prior cross-cutting measures policies in the program, particularly if core elements are spread across all MVPs. There are very few, if any, measures that would be applicable to all specialties across

medicine. For example, the CAHPS for MIPS survey measure, which perhaps seems like it would be relevant for all clinicians, is not. That survey measure is not designed for the inpatient setting and is otherwise unreportable by hospitalists. In a single MVP, there may be instances where subspecialization of clinicians who report a single MVP could all report on the same measure. We would recommend CMS address this on a case-by-case basis with the input of specialty societies and other stakeholders. We caution CMS against creating a ubiquitous policy on core elements across all MVPs.

Medicare Procedural Codes Request for Information (RFI)

Currently, MVP Participants may select any MVP to report. CMS is considering utilizing Medicare procedural codes to further facilitate more MVP specialty reporting and to encourage and potentially require specialists to report an MVP applicable to their specialty or scope of care.

SHM cautions CMS against creating policies that force clinicians into reporting a specific MVP or measure. We believe that clinicians and groups should have the ability to choose an MVP and measures that best fit their practice. We also note that numerous specialties do not have relevant MVPs, and for those that do, the MVP is not always best suited to an individual physician or group's practice patterns. When deciding on what quality measures to report, groups look at the available measures and consider them within the context of their typical work. Claims data may not be nuanced enough to ascertain differences in practice patterns, particularly for non-procedural work. We understand that CMS wants to encourage MVP adoption, however we do not believe CMS should be using claims data to tell clinicians and groups which MVP they should use.

Well-Being and Nutrition Measures Request for Information (RFI)

CMS asks for input on measures for future years of the QPP, specifically on potential new well-being and nutrition measures. While increased well-being and nutrition are worthy aims, SHM cautions that any measures in this area should be carefully weigh the administrative costs and burden associated with such measures against their true value to patient care and patient outcomes. The appropriateness of care setting for such measure must also be carefully considered. CMS should also consider expanding their definition of well-being to include measures around clinician well-being, particularly in light of high rates of burnout across the healthcare system. Given that we are currently facing a

shortage of physicians today, and expect worsening shortages in the future, the lack of attention to the impact of ever-increasing administrative burdens and the harm being done to clinician resiliency is worrisome. Well-designed measures on this topic could be tools to help identify issues and inform new programming to ensure the sustainability of medical practice in the United States.

Quality Performance Category

Proposed Measures for Removal

CMS proposes to remove two quality measures from the program: Quality ID 487 Screening for Social Drivers of Health and Quality ID 498 Connection to Community Service Provider. These measures were developed to try to acknowledge and address social determinants of health—factors that influence and affect patients' experience of care and clinical outcomes. In proposing to remove these measures, CMS uses the rationale that they are removing process measures that would no longer be considered high priority measures and alignment with removal across other CMS programs.

When these measures were being developed, SHM broadly supported the concepts behind the measures, but raised concerns about some of the specific measure details and whether individual clinicians could ultimately be held accountable to factors beyond their direct control. We also acknowledged that these measures created new or different expectations for clinicians to perform screenings on all patients and, ideally, connect patients with appropriate community-based resources if available. While imperfect, these measures created a national priority on addressing the whole needs of patients and encouraged an intertwining of clinical and community resources. These are still worthy goals that would benefit from more research and investigation.

We believe that social drivers of health continue to require agency focus and attention. We urge the agency to consider new measures or measure/programmatic adjustments around this area. Hospitalists see firsthand how, for example, food and housing insecurity can impede a patient's recovery post-discharge or force hard choices about whether they can fill a prescription or pay for groceries. In some cases, impediments like these can lead to costly readmissions and poor clinical outcomes. CMS can be a leader in encouraging and empowering clinicians and health systems to better understand and address social drivers of health and meet the needs of our patients and communities.

Topped out Measures Benchmark

SHM is disappointed with CMS' response to our comments in the CY 2025 Physician Fee Schedule proposed rule on issues with topped out measures in the Hospitalist Specialty Set. We noted that all four of the measures in the Hospitalist Specialty Set were topped out in some way, making it difficult for groups to score highly in these measures. Minute variations in measure performance can lead to wildly different scores for groups. CMS did not expand the list of measures on the topped-out benchmarking list, leaving hospitalists structurally disadvantaged in the MIPS. As stated previously, SHM estimates more than 50,000 hospitalists practice in hospitals today, roughly 5% of the total number of practicing physicians in the country, and provide care to more than 50% of hospitalized Medicare patients each year. To avoid disadvantaging a MIPS cohort of this magnitude, **we strongly urge CMS to include all the measures in the MIPS Hospitalist Specialty Set in their published list of measures available for the topped-out benchmarking.**

CMS' stated solution to create new measures is not viable in the short-term for hospitalists, and risks leaving hospitalists structurally disadvantaged if they choose to report on measures in the MIPS. We disagree that simply because some measures are commonly used across measure sets or identified as cross-cutting measures, they should not be eligible for the topped-out benchmark methodology. These are still measures that numerous specialists rely on. If CMS is concerned about clinicians selecting topped out measures to try and game their MIPS scores, we suggest CMS explore alternative policies to guard against this behavior, such as expanding the Eligible Measure Applicability (EMA) process to also look at whether a clinician could have reported on any non-topped out measures.

Cost Performance Category

Proposal to Modify MIPS Cost Measures Beginning with the CY 2026 Performance Period: Total Per Capita Cost Measure

CMS proposes substantive changes to the Total Per Capita Cost (TPCC) measure in the Cost Category of the MIPS. Specifically, CMS is proposing to change the measure specifications for triggering a candidate event to require two claims for outpatient E/M services to indicate a primary care relationship with the patient. The second service would

need to be another E/M primary care service or general primary care service from the same clinician group within 90 days. In addition, both the first and second services would have to be provided by a clinician, identified by TIN-NPI, who is not otherwise excluded from the measure based on specialty exclusion criteria. CMS also proposes to remove clinicians and their candidate events from attribution for the TPCC measure if they are an advanced care practitioner and part of a clinician group where all other non-advanced care practitioners are excluded based on specialty criteria.

SHM is supportive of these changes to the TPCC measure specifications and appreciates CMS' attention to the issues we raised in prior comments. In addition, we urge CMS to make these changes retrospective to the 2025 reporting period/2027 payment year. Hospital medicine groups can commonly be comprised of clinicians who are identified as hospitalists, internal medicine, family medicine, pediatrics, med-peds, nurse practitioners, and physician assistants. Prior MIPS performance reports have shown some hospital medicine groups being attributed cases in the TPCC measure and receiving negative performance data. This case attribution was most likely due to NPs and PAs practicing in the group and the services they may bill.

Proposal to Adopt a Two-Year Informational-Only Feedback Period for New MIPS Cost Measures

CMS proposes to adopt a 2-year informational-only feedback period for new cost measures, where a measure would not impact MIPS cost performance category scores, final scores, or payment adjustments until the third year it is implemented. CMS proposes that they would score all new cost measures for the first 2 years after the measure is initially finalized for informational-only purposes.

SHM is supportive of this informational-only feedback period for new cost measures and encourages CMS to finalize this proposal. The impact of cost measures on overall MIPS performance is immense, and issues with cost measure design can often only be detected after a measure has been implemented. Hospitalists' experience with existing cost measures has been extremely mixed, particularly as they try to understand complicated episodes of care, trigger events, and attribution methodologies. SHM believes this will give groups time to receive data on new measures, gain familiarity with the measure specifications, and raise any issues with the measures prior to their use for payment adjustments.

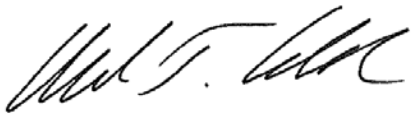
Proposed Performance Threshold for the CY 2026 Performance Period/2028 Payment Year through the CY 2028 Performance Period/2030 Payment Year

CMS proposes to continue using the mean total performance score from the CY 2017 performance period/2019 MIPS payment year. This would keep the overall MIPS performance threshold at 75 points through the 2030 MIPS payment years. **SHM supports this proposal.** We appreciate CMS' acknowledgement of the continued staffing and operational challenges in the health care system and the lack of uptake of MVPs.

Conclusion

SHM appreciates the opportunity to provide feedback on proposed rule changes for CY 2026 Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. If you have any questions or require further information, please contact SHM's Chief Legal Officer and Director of Government Relations, Josh Boswell at: jboswell@hospitalmedicine.org.

Sincerely,



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