Society of Hospital Medicine
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The Honorable John Joyce, M.D.
Co-Chair
GOP Doctors Caucus
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier, M.D.
Chair
Democratic Doctors Caucus
1110 Longworth House Office Building
Washington, DC 20515

The Honorable Greg Murphy, M.D.
Co-Chair
GOP Doctors Caucus
407 Cannon House Office Building
Washington, DC 20515

Dear Representatives Joyce, Murphy, and Schrier:

The Society of Hospital Medicine (SHM), representing the nation's more than 50,000 hospitalists, thanks you for your leadership in introducing H.R. 9693, the *Patients First Act of 2026,* and for soliciting stakeholder feedback as Congress considers reforms to the Medicare physician payment system.

Our Background – The Role of Hospitalists in Medicare

Hospitalists are physicians whose professional focus is the comprehensive medical care of hospitalized patients, providing care to millions of Medicare beneficiaries each year. In addition to managing clinical patient care, hospitalists are responsible for coordinating treatment during acute illness, improving care transitions, reducing avoidable complications and readmissions, and advancing quality improvement efforts across hospitals and health systems. This unique position affords hospitalists a distinctive role in both individual physician-level and hospital-level performance measurement programs. Hospitalists have a range of experience with participating in the two Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) pathways: The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), including having been major participants in the Bundled Payment for Care Improvement models. It is from these perspectives that we offer our comments on the *Patients First Act of 2026* and the accompanying Request for Information.

Hospital medicine has long supported efforts to create a stable, predictable, and sustainable physician payment system that appropriately serves our patients and recognizes the value hospitalists bring to the health care system. The current Medicare physician payment structure, characterized by recurring payment reductions, budget neutrality adjustments, and reimbursement updates that fail to keep pace with inflation, undermines practice sustainability

and threatens beneficiary access to care. These challenges are particularly serious in hospital medicine. Hospitalists are providing care for increasingly complex patients with fewer resources while simultaneously engaging in efforts that aren't directly compensated by Medicare, such as leading initiatives across their hospitals to improve quality, safety, care coordination, and efficiency.

We commend the legislation for advancing several important principles, including establishing a permanent physician payment update methodology, reducing administrative burden associated with quality reporting, strengthening physician involvement in measure development, improving transparency in performance assessment, and creating new pathways to support value-based care. We also respectfully offer recommendations to refine certain provisions to ensure they support the unique specialty of hospital medicine, preserve patient access, and achieve Congress's goals of improving quality while reducing unnecessary spending.

Stable Physician Payment Is Essential to Protect Medicare Beneficiary Access

Payment stability and predictability have become especially acute for hospitalists since the CY 2026 Physician Fee Schedule (PFS) final rule (CMS-1832-F) contained a provision significantly cutting the practice expense (PE) portion of physician payments for services provided in the facility setting. As a result, hospitalists have incurred an average 7% cut to their Medicare reimbursement as a direct consequence of this facility PE reduction. This reduction has significantly decreased available resources for key activities such as patient-focused quality improvement efforts, innovation, and clinician recruitment, which are all critical for purposes of delivering high-quality care and maintaining patient access. Many independent hospital medicine practices are now faced with potential consolidation as one of the few financially viable paths forward.

SHM strongly supports replacing the current cycle of temporary payment patches with a permanent update mechanism tied to inflation. The proposal to establish annual updates based on the Medicare Economic Index (MEI), while recognizing differences between qualifying and non-qualifying APM participants, represents meaningful progress toward restoring predictability in physician payment. However, we encourage Congress to continue evaluating whether updates based on MEI minus one percentage point (MEI -1) will adequately maintain physician practice sustainability over time, particularly during periods of elevated inflation. Hospital-based physicians face substantial increases in staffing, technology, compliance, and practice operations costs that may not be fully supported in payment updates below actual inflation.

We also appreciate the requirement in the legislation for annual reports on the impact of conversion factor updates on access and consolidation, as these issues deserve focused and continued oversight. This report should also include a review of the impact of the updates on the physician workforce. For this review to be meaningful for hospital-based specialties, we encourage Congress to direct that it incorporate hospital-based practice cost and workforce data developed in consultation with specialty societies representing hospital-based physicians, as hospitalized patients do not select their treating hospitalist and hospitalist practice expenses vary widely depending on employment model. This means conventional access and practice-cost measures may not fully capture the effect of payment reductions on hospital medicine. Furthermore, we recommend having the report be part of either the Medicare

Payment Advisory Commission (MedPAC) March or June report to Congress. This would ensure Congress receives independent advice on the effects of these updates.

Responses to the Request for Information

1. What offsets or "pay-fors" should be considered to fund a permanent, inflation-based physician payment update?

A sustainable physician payment system should be financed through policies that reduce fraud, waste, and abuse and address administrative inefficiencies. These solutions are detailed below:

Reduce fraud, waste, and abuse. Continued bipartisan investment in modern program integrity tools, predictive analytics, and targeted oversight can identify improper payments and fraudulent billing practices. However, oversight of these efforts is critically important to ensure they are not inadvertently and negatively impacting the ability to deliver medically necessary care.

Address administrative inefficiencies. Excessive prior authorization requirements, duplicative documentation mandates, and fragmented reporting systems create substantial costs for both medical practices and the Medicare program. We discuss specific opportunities for administrative simplification, including moving away from reporting programs that have not improved quality, in our response to Question 3 below.

Importantly, physician payment updates should not be financed through reductions to other areas of physician reimbursement, as continued erosion of physician payment threatens access, accelerates practice consolidation, and undermines the long-term goals of value-based care.

2. Are there areas within Medicare where there is systematic overpayment?

A few areas warrant further evaluation:

- Payment policies that do not reflect current evidence-based practice patterns;
- Differences in per-beneficiary spending between Medicare Advantage (MA) and traditional Medicare, which independent analyses have identified as warranting further evaluation. For example, the Medicare Payment Advisory Commission (MedPAC) estimates that, in 2025, payments to MA plans exceed what spending would have been in traditional Medicare by 20%.[1]
- Improper payments resulting from fraud, waste, or abuse;

[1] Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report," chap. 11 in Report to the Congress: Medicare Payment Policy (Washington, DC: MedPAC, March 2025), 338, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf#page=22.

SHM supports careful analysis of payment policies to ensure Medicare resources are directed toward services that improve patient outcomes and preserve access. Efforts to identify overpayments should be evidence-based, clinically informed, and avoid unintended consequences that could reduce access for medically complex patients.

3. How can care be provided less expensively without compromising patient access?

Hospitalists have extensive experience developing and implementing care models that improve outcomes while reducing unnecessary utilization. Congress should consider policies that support:

Improved care transitions. Effective communication and coordination between hospitals, primary care physicians, specialists, post-acute providers, and community organizations reduce avoidable readmissions and emergency department visits.

Ensure patients receive care in the most appropriate setting. Congress should target policies that are outdated and/or impede patients getting the care they need in the most appropriate setting. Existing Medicare policy, the three-day stay rule for skilled nursing facility (SNF) coverage, has been in effect since the early days of the Medicare program when average lengths of stay in the hospital were 8 days or more, compared to roughly 4.5 to 5 days today. Given this change, the policy now prevents placing patients in more appropriate care settings, while patients held under observation status may be discharged home without SNF coverage because observation days do not count toward the requirement. Both outcomes increase Medicare spending, whether by paying for care that could be delivered in a lower-cost setting or by raising the risk of complications and readmission for patients who would have benefited from SNF care.

We encourage Congress to waive the three-day inpatient stay requirement so that SNF coverage is determined by clinical need rather than by length of hospitalization, as CMS did nationwide during the COVID-19 public health emergency. At a minimum, Congress should count time spent under observation status toward the requirement, as the bipartisan Improving Access to Medicare Coverage Act (H.R. 3954/S. 4641) would do.

Beyond the effect on patient cost-sharing and SNF access, the process of making and defending inpatient-versus-observation determinations itself imposes a substantial, largely uncompensated administrative burden on hospital medicine programs. Every admission requires a hospitalist, frequently supported by a physician advisor and utilization review staff, to apply complex and often plan-specific medical necessity criteria, document severity of illness and intensity of service in real time, and in many cases execute a Condition Code 44 status change or defend the determination through a retrospective secondary review or peer-to-peer conversation. Although the CY 2024 MA and Part D final rule (CMS-4201-F) requires MA organizations to apply the two-midnight rule when making inpatient status determinations, plans retain broad discretion to review and downgrade claims outside of the two-midnight presumption used in traditional Medicare, and the rule carries no meaningful penalty for noncompliance. This administrative infrastructure represents exactly the kind of hospital-based practice

cost that is not reflected in MEI-based payment updates, reinforcing our concern, discussed above, that MEI -1 may understate the true cost of sustaining hospital medicine practices.

Administrative simplification. Reducing unnecessary documentation, streamlining reporting requirements, and aligning quality programs would free physician time for patient care. This includes moving away from mandatory reporting programs that have been proven not to improve quality. Compliance with these programs is administratively burdensome and costly. For example, a big financial beneficiary to MIPS and its predecessors has been the vendors and consultants who, due to program complexity, have become necessary components for compliance. This represents resources that have been unfortunately diverted from direct patient care and have not improved patient outcomes.

Reduce administrative burden imposed by MA plans. As MA enrollment now accounts for more than half of all Medicare beneficiaries, hospitalists bear a disproportionate share of the administrative burden associated with MA utilization management. A 2025 National physician survey reported an average of 40 prior authorization requests per week, consuming approximately 13 hours of physician and staff time, with 40 percent of practices now employing staff solely dedicated to prior authorization.[2] These costs are not captured in current practice expense calculations. HHS Office of Inspector General (OIG) reviews have repeatedly found that a substantial share of these denials do not withstand scrutiny: a 2022 OIG report found that 13 percent of denied prior authorization requests and 18 percent of denied payment requests actually met Medicare coverage rules,[3] and more recent OIG reviews have found that MA organizations overturn nearly all appealed prior authorization denials for skilled nursing facility admission, raising serious questions about the accuracy of initial determinations.[4] While the CY 2024 MA final rule took welcome steps toward aligning MA utilization management with traditional Medicare, including barring the use of internally developed algorithms as the sole basis for medical necessity denials, it attached no meaningful enforcement penalty, and hospitalists continue to encounter plan-specific criteria, retrospective status downgrades, and burdensome peer-to-peer review requirements that consume time that could otherwise be spent on direct patient care. We encourage Congress to build on this progress by directing CMS to attach real enforcement mechanisms to MA organizations' compliance with Medicare coverage and status-determination rules, require that MA medical necessity criteria for admission and level-of-care decisions be standardized, transparent, and

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[2] American Medical Association, 2025 AMA Prior Authorization Physician Survey (Chicago: American Medical Association, 2026), https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[3] HHS Office of Inspector General, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, OEI-09-18-00260 (Washington, DC: HHS OIG, April 2022), https://oig.hhs.gov/documents/evaluation/3150/OEI-09-18-00260-Complete%20Report.pdf.

[4] HHS Office of Inspector General, Medicare Advantage Organizations Overturned Nearly All Appealed Prior Authorization Denials for Skilled Nursing Facility Admission, Raising Concerns About Initial Denials, OEI-09-24-00331 (Washington, DC: HHS OIG, June 2026), https://oig.hhs.gov/reports/all/2026/medicare-advantage-organizations-overturned-nearly-all-appealed-prior-authorization-denials-for-skilled-nursing-facility-admission-raising-concerns-about-initial-denials/. See also HHS Office of Inspector General, The Three Largest Medicare Advantage Organizations Denied Requests for Long-Term Acute Care and Inpatient Rehabilitation at Some of the Highest Rates, OEI-09-24-00330 (Washington, DC: HHS OIG, June 2026), https://oig.hhs.gov/reports/all/2026/the-three-largest-medicare-advantage-organizations-denied-requests-for-long-term-acute-care-and-inpatient-rehabilitation-at-some-of-the-highest-rates/.

publicly available, and advance real-time electronic prior authorization requirements, consistent with the bipartisan goals of the Improving Seniors' Timely Access to Care Act (H.R.3514/S.1816), as a pay-for that reduces both plan and provider administrative costs.

Telehealth and digital tools. Appropriate use of telehealth, remote monitoring, and virtual consultation can improve access and reduce unnecessary utilization.

Additional Comments on the Patients First Act

We strongly support efforts to reduce administrative burden by improving physician involvement in quality measurement programs. The proposed Quality Reform Task Force and requirements for specialty representation recognize that physicians are best positioned to determine which measures meaningfully reflect quality and patient outcomes. We also support greater transparency in claims-based performance measurement and timely physician feedback, which can improve trust in performance programs and facilitate quality improvement.

At the same time, we encourage Congress to ensure that reforms are inclusive of all physician specialties. We caution that the Patient Outcome Improvement National Tabulation System (POINTS) program risks recreating many of the same challenges currently in the MIPS and ultimately will not yield useful and actionable information for clinicians if those challenges are recreated. One of the largest challenges that hospitalists face in quality measurement is attribution of a metric to an individual's performance. In interdisciplinary, team-based care, it is nearly impossible to create measure attribution rules that make clinical sense. In the hospital, team-based care goes beyond MIPS- or POINTS-eligible professionals to include nurses, techs, and numerous other clinical and non-clinical staff who may not bill the Medicare PFS or exist under the hospitalists' Taxpayer ID Number (TIN). POINTS, like the MIPS, seems to assess performance at either the individual or group level, but the measures are typically not fairly or reasonably attributable at these levels consistently. This issue would be exacerbated with the introduction of a new Care Efficiency Category with measures that are likely best or most appropriate to measure at the health system level due to all the potential factors affecting performance. There are also many factors that fall outside of physician scope and control, including patient complexity, social risk factors, availability of community resources, and care decisions made by patients themselves or unrelated providers. We urge the Caucuses to look beyond the various silos within the Medicare payment systems when thinking about how to incentivize and reimburse for improving the quality and efficiency of care.

Hospital medicine differs from both primary care and procedure-based specialties, and payment models should recognize the important role hospitalists play in both caring for and coordinating care for acutely ill and medically complex patients. Hospitalists have demonstrated that physician-led quality initiatives, including enhanced discharge planning, medication reconciliation, multidisciplinary rounds, sepsis management, and evidence-based care pathways, can simultaneously improve quality and lower costs. However, much of this work takes place at the hospital or systems level and remains both uncompensated and unrecognized in physician quality reporting programs. New payment models should create meaningful opportunities for participation by hospital-based physicians and should avoid inadvertently favoring certain specialties over others.

Specifically, we reviewed Section 102 of the legislation, the **Hybrid Payment Model for Primary Care,** with interest**.** We encourage the inclusion of permissive language in this section that would enable conceptually similar models to be developed, tested, and, if successful, implemented for additional specialties such as hospital medicine. Similar to primary care, hospitalists care for a wide range of patients and conditions, which has presented challenges with alternative payment model participation given many of the physician-initiated payment models developed to date have been condition- or procedure-focused.

Finally, Congress should continue monitoring the impact of payment policy on physician workforce trends, independent practice sustainability, and beneficiary access. The growing mismatch between physician payment updates and practice costs contributes to workforce shortages and practice consolidation, both of which negatively impact access to care, particularly in rural and underserved communities.

Conclusion

SHM appreciates the thoughtful approach reflected in the *Patients First Act of 2026* and commends Congress for pursuing long-overdue reforms to Medicare physician payment. Stable payment updates, reduced administrative burden, meaningful quality measurement, and stronger physician leadership in value-based care are all essential pieces to preserving access to quality care for Medicare beneficiaries while improving the efficiency of the overall health care system.

We look forward to working with you to refine and strengthen this legislation so that it supports all physician specialties, promotes patient-centered care, and establishes a sustainable foundation for Medicare physician payment for years to come.

Sincerely,

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President
Society of Hospital Medicine