Society of Hospital Medicine
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September 14, 2026

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Oz,

The Society of Hospital Medicine (SHM), representing the nation's more than 50,000 hospitalists, appreciates the opportunity to provide comments on the proposed rule: *Medicare and Medicaid Programs; CY 2027 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-1848-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:

Updates to Practice Expense Methodology – Site of Service Differential

SHM urges CMS to reconsider the site of service differential established in the CY 2026 Physician Fee Schedule Final Rule. The policy has resulted in an estimated 7 percent cut to Medicare reimbursement for hospitalists, regardless of their employment structure. We continue to alert the agency of the destructive impact this policy is having on the healthcare system, particularly for independent hospital medicine groups. After eight months of experience with the adjusted payment rates, we have confirmed the magnitude of the cut and learned how hospital medicine groups are struggling as a result.

The cuts are fueling pressure on independent hospital medicine groups to consolidate with larger entities or to sell their practices to hospitals and health systems entirely. In the shorter term, hospital medicine groups have had to make difficult financial decisions, including:

- Salary freezes and salary reductions for physicians;
- Hiring freezes or staffing reductions for physicians;
- Hiring freezes and reductions in administrative positions that are necessary to support patient care;
- Limiting educational and leadership development opportunities, including cuts to Continuing Medical Education (CME) funding;
- Cutting health and other benefit plans; and/or
- Curtailing recruitment and marketing expenses, making it increasingly difficult to fully staff programs and remain competitive in the marketplace.

These cuts are severely undermining the foundational strengths of hospital medicine groups—jeopardizing their clinical autonomy and quality, operational agility, distinct culture, and long-term sustainability. Left unaddressed, this policy is perpetuating three critical risks:

- **Destabilizing Practice Solvency:** By forcing independent groups to absorb financial burdens that are out of step with their actual expenses, these cuts threaten basic operational solvency, leaving direct hospital employment as the only remaining pathway for survival.

- **Driving Market Consolidation:** Financially strained independent practices are increasingly forced to merge with larger corporate management companies or health systems as a last resort, accelerating broader healthcare consolidation and reducing practice diversity.

- **Compromising Patient Care:** The loss of necessary practice expense funding is forcing physicians to absorb administrative burdens without support, or to provide the same amount of care with fewer physicians. Staffing cuts or freezes will exacerbate issues like ED boarding and hamper the ability to follow up with patients or their primary care physicians post-discharge. Groups are also being forced to pull out of higher-cost practice environments to maintain financial solvency, which often means fewer services in rural or underserved areas.

These are not hypothetical scenarios; they are already escalating physician burnout, degrading operational efficiency, and negatively impacting patient outcomes, all of which ultimately cause harm to Medicare beneficiaries.

The arbitrary nature of the cut—both in its size and its indiscriminate targeting—is reason alone to repeal or rework this policy. It is built on incorrect assumptions, not data, and we urge the agency to study the issue further, test its hypotheses, and only then issue proposals for an appropriate policy. To date, CMS has not presented any data indicating:

- Why the previous difference in PE values between hospital visit E/M codes and similar office/outpatient E/M codes did not sufficiently address the agency's overpayment concerns; or
- What justified the 50 percent reduction in facility PE rates.

As we articulated in our comment letter regarding the 2026 MPFS Proposed Rule and in follow-up correspondence, hospital medicine groups bear practice expenses regardless of their employment structure. Independent groups that contract with hospitals to provide inpatient hospital medicine services have PE needs to maintain and manage their operations that are not entirely dissimilar from those of the outpatient practices this policy purports to support.

Clarifying the Financial Relationship Between Hospitals and Hospital Medicine Groups

We are concerned that the site of service differential rests on a mistaken assumption: that because hospitalists furnish services in the facility setting, hospitals are effectively covering their practice expenses. This is not how these arrangements work, and we believe it is important to correct the record.

Independent hospital medicine groups are separate legal and financial entities from the hospitals in which their physicians practice. Like any independent physician practice, these groups are responsible for their own overhead—including billing and coding software and staff; payer contracting, claims workers, and other revenue cycle personnel; quality reporting staff and infrastructure; practice management and administrative personnel; malpractice insurance and legal personnel; health and retirement benefits; recruiting, credentialing and training costs; and scheduling and staffing systems. None of these costs are absorbed by the hospital simply because the group's physicians see patients on hospital premises.

The contractual relationship between a hospital and an independent hospital medicine group typically consists of two separate financial streams, and it is critical that CMS not conflate them:

1. **Professional fee billing.** Hospitalists bill Medicare and other payers directly for the professional (physician) services they furnish, using the E/M and other CPT codes at issue in this rule. This revenue is the group's primary source of funding for its practice expenses, and it is billed and paid identically regardless of whether the group is independent or hospital-employed.

2. **Support for uncompensated work.** Hospital medicine is a value-based specialty and is crucial to quality and efficiency in the hospital setting. This value is derived from both the clinical care they provide and the quality improvement and systems efficiency work they do. As such, many hospitals provide a separate stipend, subsidy, or coverage payment to hospital medicine groups (independent or employed) to offset the gap between what a program can bill and collect for professional services and the cost of providing the staffing coverage the hospital requires—for example, quality improvement and efficiency efforts, nights, weekends, and personnel who respond to critically ill hospitalized patients who are in emergency situations. These payments compensate the group for guaranteeing physician availability and meeting hospital-specific coverage obligations; they are not a reimbursement of practice expense and are not tied to E/M coding or volume like PE payments under the fee schedule. These stipends are typically negotiated based on hospital staffing needs and market coverage rates rather than the cost of running a medical practice.

Critically, this coverage support is not unique to independent groups—hospital-employed physicians often require similar payments, since hospital-based E/M revenue alone frequently does not cover the cost of 24/7 staffing. The presence of a coverage payment therefore says nothing about who is bearing a group's practice expenses, and it cannot be used as a proxy for whether a group's PE needs are being met by the hospital. In both employment models, the practice expense components embedded in the professional fee—and the actual costs of running a medical practice—are borne by the physician group; they are not automatically shifted to the hospital because services are furnished in a facility setting.

For these reasons, CMS's premise that facility-based practice expense should be reduced because hospitals are presumed to be absorbing those costs is not supported by how hospital medicine groups are financed. Hospital Medicine groups continue to incur the full range of practice expenses regardless of where their physicians provide care, and the site of service differential penalizes them for costs the hospital is not, in fact, paying.

Response to CMS Request on Identifying Employed Groups

SHM continues to believe the policy should be repealed in its entirety. It is damaging to the entire field of hospital medicine and many other hospital-based specialties regardless of employment model, and it has created a cascade of problems. That said, we acknowledge CMS's request for feedback. In the proposed rule, CMS asks whether it should consider a more targeted approach to the site of service differential, such as having employed groups identify themselves.

We believe a modifier could, in theory, offer a more targeted approach but only if it can be implemented in an administratively realistic way, which is not yet clear. Requiring hospital-

employed groups to self-identify—thereby subjecting themselves to a practice expense RVU reduction—creates a disincentive to report: these groups would have no compelling reason to use the modifier, and uptake would likely be minimal. A more workable design would instead allow independent groups to identify themselves. Because independent groups would have a genuine incentive to use the modifier, this approach would likely increase uptake and give CMS a clearer, more accurate picture of employment structures nationwide.

SHM welcomes the opportunity to further discuss this concept, or other solutions, as CMS considers next steps.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

CMS is proposing to make an adjustment to payments when there is a stand-alone office/outpatient E/M visit billed using modifier -25 and a global surgery bundle, which includes E/M visit(s), billed on the same day. Specifically, it is proposing to pay for the most expensive service at 100% and all other services at 50% of their value. CMS is also soliciting comments on whether this policy should apply to other E/M visits, such as inpatient E/M visits.

SHM opposes expanding this policy to inpatient E/M visits and cautions the agency against finalizing the proposal to apply to office/outpatient E/M visits. Multispecialty group practices are common in the healthcare system, and we do not believe this policy accounts for situations in which legitimate, separately billable services are performed by other providers who happen to be in the same group on the same day as a global surgical bundle. We agree there may be instances where E/M services included in the bundle are not being performed or are being performed by clinicians other than the one billing the bundle. However, we urge CMS to contemplate how to address these issues with more targeted efforts. This overbroad policy risks harming patient care by penalizing efficiency and disincentivizing co-management and team-based care, particularly if expanded to hospital visit E/M codes.

Quality Payment Program

Transforming MIPS: MIPS Value Pathway (MVP) Strategy

SHM appreciates the intent to simplify the MIPS by implementing MVPs and broadly supports the policies for MVPs that streamline or truncate requirements, make measure selection easier, and, ideally, generate fairer comparisons.

SHM continues to raise concern about the added administrative burden associated with subgroup reporting in MVPs, particularly in light of the proposal to make MVP reporting mandatory for the 2029 Reporting Year. Different subgroups within multispecialty groups may not have any experience with reporting in these programs. We acknowledge some specialties

believe there is a benefit to subgroup reporting – these are likely specialties with measures that are meaningful and actionable. However, many specialties, like hospitalists, have measures that are not. When you look at the measures for hospitalists, there are some extremely broad-based measures that may apply to most of their patients and some very narrowly focused measures that only apply to a small subset of patients. The measures and the MIPS overall do not give a complete or accurate picture of hospitalists and their vital work in the healthcare system.

General MVP Comments: Foundational Layer

Earlier this year, SHM provided comments on the Hospitalist and Critical Care MVP candidate that expressed concern about the foundational layer for all MVPs. We are disappointed that CMS does not address these concerns in this proposed rule and urge the agency to reconsider the foundational layer for hospitalists as it is not currently relevant or applicable to hospitalists. We have continually warned CMS against one-size-fits-all approaches to the MIPS and issues with the foundational layer highlight the challenges inherent in this strategy.

The Population Health Measure Q484: Clinician and Clinician Group Risk-standardized Hospital Admissions Rates for Patients with Multiple Chronic Conditions is inappropriate for hospitalists. The measure tracks the unplanned admission rates for patients with multiple chronic conditions and is designed around measuring the outcomes and quality of ambulatory/outpatient care. Given that hospitalists care for hospitalized patients, their admission rate would be 100%. This measure cannot be part of a hospitalist MVP.

The Population Health Measure Q479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Eligible Clinician Groups may not be an appropriate clinician-level measure, and we have concerns about its inclusion in the MVP. SHM has long advocated for the use of smaller episode windows for readmission measures, to better target readmissions that are actionable by the care provided by hospitals and hospital-based care teams. Current evidence suggests that the window of impact for preventing readmissions is much shorter than 30 days and may be as short as 7 days. Therefore, the measure as structured makes hospitalists accountable for factors well outside of their control. We urge CMS to narrow the episode window for these measures to focus on the modifiable factors within hospitals and clinicians' control to prevent or reduce readmissions.

Promoting Interoperability (PI) is a category of the MIPS that hospitalists have always been exempt from, due to the nature of their relationship with hospitals. Hospitals have their own PI program, and the longstanding exemption recognizes that hospitalists do not control the selection or implementation of Electronic Health Record systems in the hospital. The Hospitalist MVP cannot have PI as part of its foundational layer, and we urge CMS to clarify how existing legislative exemptions from PI interact with the MVP reporting and scoring. This is especially

salient given that subgroup reporting will create cohorts of hospitalists within multispecialty groups.

General MVP Comments: Facility-based Measurement

We ask CMS to confirm that, with the transition to mandatory MVP reporting, facility-based measurement will still be an option for clinicians in the program. We have consistently advocated for this as an option for hospitalists and other clinicians to align their performance with their hospital's performance on quality and cost measures. It would be helpful for CMS to also provide guidance on how facility-based measurement will fit into MVP scoring and final score calculations. To date, we have not seen any data on the use of facility-based measurement and ask CMS to publish or share more data to better understand whether it is working and how groups who utilize this option are performing in the MIPS.

We also continue to ask CMS to explore how they might incorporate selected measures from the Hospital Value-Based Purchasing (HVBP) and Inpatient Quality Reporting programs into the MVP structure as allowed by statute. Currently the facility-based measurement option assigns clinicians a MIPS score based on their hospital's HVBP total score. SHM has long encouraged CMS to use specific measures from the hospital programs, making the facility measurement option more meaningful and applicable to the specific work of hospitalists. Different hospitals may incentivize hospitalist groups for different clinical measures and goals, making specific facility measures more relevant to that group's performance. We believe this more nuanced alignment can both decrease the administrative burden associated with the MIPS and MVPs and increase the applicability for clinicians and groups. We would like to work with CMS more on this concept.

Hospitalist MVP Proposal

SHM appreciates CMS' efforts to develop a hospitalist MVP and would like to provide feedback on the measures proposed for inclusion. We are generally supportive of the proposed MVP and encourage it to be finalized. However, we do ask CMS to address issues with the foundational layer, as detailed above.

We also support the designation of three measures in the MVP as "core measures," including:

- **Q005:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **Q008:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **Q047:** Advance Care Plan

We believe these three measures are all broadly applicable to hospitalists and generally reportable. However, we do want to note that Q005 and Q008 are substantially more complex to capture, depend on condition-specific patient populations, and may present significant reporting burden for many hospitalist groups

CMS proposes to include measure **Q238**: Use of High-Risk Medications in Older Adults in the Hospitalist MVP. This measure has not previously been included in the Hospitalist Specialty Set of measures for the MIPS. SHM agrees with the clinical concept of this measure as an important patient safety measure. However, we have questions about the measure specifications and performance on the measure and ask for clarification on situations in which patients may reasonably be prescribed two high-risk medications from the same class. These could include cases where patients are experiencing side effects or a lack of response to the first medication, necessitating trying other drugs. Alternatively, there could be patients who may need existing outpatient prescriptions filled in the inpatient setting, such as for benzodiazepines, but also clinically require other drugs on the high-risk list. We would like to see more data, if available, about prior performance on this measure and ask CMS to consider alternative ways to measure and assess medication safety events.

We ask for CMS to add measure **Q130**: Documentation of Current Medications in the Medical Record" to the MVP. This measure is currently in the Hospitalist Specialty Set, is well known by hospitalists who participate in the MIPS and is generally applicable to the care hospitalists provide. We also believe this measure could be considered a core measure, due to its cross-cutting nature.

Proposal to Designate MIPS Core Measures and Proposal to Remove High-Priority Measure Designation

CMS proposes to remove the high-priority measure designation from measures across the MIPS and create a broader category of "MIPS Core Measures." **SHM is supportive of these proposals.** We appreciate CMS' acknowledgment that many specialty measure sets in the MIPS and measure lists in MVPs did not have sufficient or available outcome or high-priority measures. The expanded criteria for core measures enable prioritization of outcome measures when available and support the reporting of measures that are operationally feasible and reflective of the care provided. We believe this proposal reduces administrative complexity of the program and recognizes the reality of current measure inventories.

We are also supportive of CMS' proposal to require the reporting of at least one core measure, regardless of whether they are reporting via the traditional MIPS or MVPs. This proposal would replace the requirement for reporting an outcome measure, or if one is not

available, a high-priority measure. We believe this is reasonable and it is feasible to require reporting on one core measure, given the expanded criteria for identifying core measures.

Proposal to Score Topped Out MIPS Core Measures According to Defined Topped Out Benchmark

CMS proposes a change to topped out measure scoring for Core Measures to enable a full score of 1-10 for these measures, exempting them from the 7-point topped out scoring cap. We previously identified and asked CMS to include the topped out measures in the hospitalist specialty set in the topped-out benchmark methodology. Hospitalists have few measures to report on in the MIPS and all four are topped out. This proposal, combined with the proposed identification of three core measures in the Hospitalist MVP, would address this issue for hospitalists and eliminate the structural disadvantage faced by hospitalists in the Quality Category. **SHM supports this proposal.**

MVP Scoring Request for Information

SHM appreciates that, as CMS is beginning to transition fully to MVPs, it is considering how to adjust the scoring rules. Broadly, SHM asks for fair comparison pools throughout CMS' programs. Particularly given the variance of measures across MVPs, we believe it is important that CMS create a scoring methodology that enables a reasonable comparison both within an MVP and between MVPs.

Current policy gives MIPS participants a score based on their performance on measures and activities in the four MIPS categories. There are likely scoring distortions based on the availability of quality measures and the applicability of cost measures. These are further potentially affected by other existing scoring rules, like the topped-out measure scoring. For example, nearly all measures in the hospitalist specialty set are topped out, but not currently included in the topped-out benchmark, meaning those measures are only able to get a score of 7 out of 10 points. We appreciate that CMS has taken steps to address some of these issues in this proposed rule.

We are supportive of the concept of normalizing scores within an MVP, such that performance is compared to other, similar clinicians. However, we urge CMS to model potential scoring approaches and provide public results for feedback. We do have some concerns that this normalization could result in minute variations within an MVP resulting in very different final scores in the overall program. This is similar to scores on topped out measures being differentiated by only tiny variations in performance.

CMS also asks about other potential pathways to incentivize high performance. We would not support policies that would yield a greater number of clinicians receiving more or higher penalties within the program.

Given the breadth of potential options explored in this RFI, we urge CMS to take feedback from stakeholders and do an additional Request for Information with more modeling and data. It is challenging to evaluate the trade-offs associated with these alternatives without more information, particularly their impact on individual clinicians reporting in the program and how small practices and rural practices may fare. It would be helpful to see how different scoring policies would change how many participants receive penalties or bonuses, and whether these variations are due to actual performance differences or artifacts of policy choices. With limited MVP uptake to date, it may be worth considering proposing a bridge year or two with very limited risk at the start of mandatory MVP reporting. This would create an opportunity to collect detailed information about MVP performance so stakeholders can provide CMS with more informed feedback.

Conclusion

SHM appreciates the opportunity to provide feedback on proposed rule changes for CY 2027 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,

Efrén C. Manjarrez, MD, SFHM
President
Society of Hospital Medicine