November 14, 2025

The Honorable John Thune
Majority Leader
U.S. Senate
Room S-230, The Capitol
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Room S-221, The Capitol
Washington, DC 20510

The Honorable Mike Johnson
Speaker
Room H-232, The Capitol
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
Room H-204, The Capitol
Washington, DC 20515

Dear Leader Thune, Leader Schumer, Speaker Johnson and Leader Jeffries,

On behalf of the undersigned organizations, we urge Congress to halt a portion of the recently finalized rule published by the Centers for Medicare & Medicaid Services (CMS) on October 31st. The CY 2026 Physician Fee Schedule final rule (CMS-1832-F) contained a provision significantly cutting the practice expense portion of physician payments for services provided in the facility setting. **Congress must act immediately to stop this arbitrary cut to facility-based practice expense prior to its implementation on January 1, 2026.**

Cuts to Practice Expense will be destabilizing to the healthcare system, causing significant disruption in access to healthcare services, particularly for those in rural and underserved areas, by removing urgently needed resources from physicians. Adequate payment to support access to specialty care is paramount to ensure that there are enough health care providers to treat the Medicare population.
For example:

- Hospitalists, who practice exclusively in the hospital setting and predominantly bill a small set of Evaluation & Management codes, are set to face an estimated 7% cut to their Medicare reimbursement as a direct consequence of this facility PE reduction. This reduction will significantly decrease 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.

- Infectious disease physicians face an estimated 6% cut overall, and a 9% cut for facility-based ID physicians. Practice expense cuts are expected to directly reduce resources for services including infection prevention and control, antimicrobial and diagnostic stewardship, multidisciplinary care coordination and outbreak readiness and response. It is particularly problematic for this policy to take effect at the height of flu season in January.
- The implementation of this policy may have unintended consequences for training the future primary care workforce. Facility-based primary care clinics serve as training sites for internal medicine residencies. Should the financial viability of these sites erode, it will undermine the primary care training pipeline at a time when there is already a shortage of general internal medicine physicians.
- Anesthesiologists and especially those specializing in critical care medicine, who care for the sickest patients in intensive care units (ICUs) and operating rooms will be facing significant payment cuts. As a result, hospitals will struggle to have the necessary resources to provide urgent life-saving services. Anesthesiologists and intensivists routinely provide services in facility settings that cannot be easily relocated to or feasibly performed in non-facility settings (e.g., critical care).
- CMS does not consider specialties that have a high percentage of privately owned practices, such as ophthalmology, where 70.4% of ophthalmologists are in private practice. Most ophthalmologists do more than perform surgery all day and maintain an office where patients are seen for pre- and postoperative visits, care for chronic conditions such as diabetic retinopathy and glaucoma, and general eye exams. They continue to incur the indirect costs of keeping their practice open, whether they are performing surgery or delivering in-office care.
- Retina specialists treat a variety of retina diseases ranging from chronic conditions (e.g., age-related macular degeneration and diabetic retinopathy) to acute conditions (e.g., surgeries to repair macular hole repairs, retinal detachments, and ocular trauma). In general, chronic conditions are treated in the office and acute conditions are treated surgically in the OR. When a retina specialist leaves the office to perform a surgery, they still need to pay their overhead and administrative costs. By cutting indirect practice expense after years of not providing inflationary adjustments, CMS will likely force many private practice retina specialists, who are operating on slim margins, to close their offices.
- Plastic surgeons are essential to comprehensive patient care, frequently assisting with wound management, defect closure, and cancer reconstruction—all services that would be jeopardized by the PE cuts. Moreover, many reconstructive surgeons, particularly those whose compensation depends on cash collections rather than RVUs, would face unsustainable practice costs, mirroring trends seen in other specialties where rising overhead has already forced physicians to reduce outpatient services and compromise continuity of care.
- The specialty of endocrinology continues to see declines in workforce. Endocrinologists provide care, and monitor treatment for some of the most

common, complex and costly conditions affecting the Medicare population, including diabetes, obesity, osteoporosis, and thyroid diseases. Reducing physician payments may force many endocrinologists to shutter their practices, reducing access to the very services needed to meet the administration's goals of reducing the growing burden of chronic disease. Without adequate reimbursement, endocrinologists may be forced to shutter their practices.

- Hematology is experiencing workforce shortages, especially in rural communities where the adequacy of hematologists is 29%. Payment reductions to an already strained workforce may have an adverse impact on access to life-saving care for many conditions affecting the Medicare population including leukemia, lymphoma, and multiple myeloma. Access to treatments like bone marrow and stem cell transplants, CAR T-cell therapy and use of monoclonal antibodies must be preserved. Hematologists face an 11% payment reduction for services performed in the facility setting if this policy is not repealed.
- Physical Medicine & Rehabilitation (PM&R) physicians practice in a variety of settings including ambulatory surgical centers and skilled and non-skilled nursing facility settings, in addition to hospital settings. These physicians incur similar overhead costs regardless of setting that would not be adequately reimbursed under the finalized policy. For example, under the new policy, practice expense for patient visits at nursing facilities (non-facility) will be paid at a higher rate than practice expense for patient visits at skilled nursing facilities (facility), despite these services having the same practice expense costs.
- Emergency physicians, required under the Emergency Treatment and Labor Act (EMTALA) to treat all patients regardless of ability to pay, will see steep practice expense reductions that effectively erase recent congressional relief and jeopardize the stability of independent groups, rural access, and the nation's emergency care safety net.
- Echocardiography services face significant payment reductions under the facility PE cuts, with interventional transesophageal echocardiography facing an 11% cut. This code covers procedures that can only be performed in the facility setting, making it impossible for providers to avoid the cuts by shifting to non-facility settings. These cuts threaten to slow innovation in the rapidly growing field of structural heart imaging, where real-time echocardiographic guidance is essential for procedures such as transcatheter valve replacements and structural defect closures.
- Neurosurgeons face an estimated 5% overall cut to PE payments, and a 7% cut for procedures performed in the facility setting. These reductions disproportionately impact neurosurgery, as the vast majority of services to treat conditions of the brain and spine must be performed in hospitals due to their complexity, the invasiveness of the procedures, the underlying physical condition of the patient, and the critical need for recovery time and postoperative monitoring. Furthermore, while surgeons are in the operating room, their offices continue to function and incur overhead costs that must be adequately reflected in the valuation of facility indirect PE. These

cuts risk the accessibility and affordability of high-quality care for Medicare beneficiaries and the financial viability of neurosurgical practices.

- While CMS assumes hospital-employed physicians have overhead absorbed by their institution, this does not reflect the numerous arrangements facilities have with gastroenterology departments. Practice expense costs are often charged to the GI department by the hospital. This can take the form of contracts that include paying rent or leasing space in the hospital based on square footage used, paying for scheduling, staffing, billing staff, etc. Additionally, independent gastroenterologists must maintain offices, staff, and billing infrastructure even when performing procedures in hospitals or in ambulatory surgical centers (ASCs).
- Many HIV clinics are facility-based and are already facing reductions in funding due to significant cuts to the Medicaid program and threats to the Ryan White HIV/AIDS Program. Further cuts in support for clinical staff will impact patient care leaving people with HIV without timely access to the care and treatment vital to their health and that stops HIV transmissions.

Many specialists are classified as "facility-based" but **work as independent practices or professional corporations and are not directly salaried by a hospital, as the rule suggests.** As a result, they incur rent for their own office space and utility expenses, employ and train administrative and clinical support staff, and shoulder ongoing costs for equipment, information technology, quality improvement programs, biosafety and compliance infrastructure, which should be adequately compensated by CMS. Shifting all indirect payments to the facility fee would leave these independent practices uncompensated and create a financially unsustainable model for non-hospital-employed physicians. When physicians are directly employed by the hospital, ultimately the hospital may receive payment for both the professional and facility claims. For example, medically fragile patients may require care in the facility setting for procedures that are covered in the office setting.

Conversely, some complex procedures cannot be safely performed in the office setting, and which CMS only covers in a facility setting. Patient safety and lack of CMS coverage in the office setting for all procedures do not appear to have been considered in developing the current proposal. It penalizes both facility-based physicians and independent practitioners who must perform some procedures in the facility setting either for patient safety for medically fragile patients or because CMS does not cover all procedures in the office setting. Office-based endoscopy is rare and almost exclusively limited to New York due to the state's rules regulating ASCs. Attempting to incentivize an increase in procedure volume in the office-setting will inevitably lengthen wait times and reduce access for patients requiring care in the facility as physicians shift their focus to office-based cases.

These cuts will have an immediate impact on staffing and retention and will force health care facilities to scale back investments in new staff and operational innovations – all of

which will have a negative impact on patients. Payment cuts will be particularly damaging to independent physician groups which operate as small businesses.

Independent physician groups operate around the country, tending to be smaller local, rural or regional groups. Groups like these are reliant on their expected venue for services provided, and certainly expend significant practice expense. These physician groups do not have the ability to absorb significant cuts to payments the way a large health system may be able. These cuts will force many independent physician 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. CMS built these PE cuts on the assumption that CMS is overpaying for PE in the facility setting. The agency's theory is that as direct employment by hospitals and health systems for certain specialties has increased, the facilities themselves would cover practice expenses related to those providers. However, the facility PE rate is already lower than the non-facility rate. CMS has not demonstrated why the existing differential between facility and non-facility PE values is insufficient.

CMS proposed and finalized this cut while simultaneously asking for data to prove or disprove its assertion that existing facility PE rates were too high. We believe this approach is counterintuitive to the goals of the agency, and that CMS should make data-driven, not assumption-driven decisions. Furthermore, the time between the release of the final rule in November 2025 and the implementation of the policy on January 1, 2026, is not adequate for physicians to prepare for the performance of these procedures in the office setting.

Halting these cuts will not change the conversion factor or require additional investment from Congress into the Medicare Trust Fund. The cut was a restructuring of value within Practice Expense, which redistributed PE relative value units (RVUs) from the facility to non-facility settings, and so the policy is budget neutral. **We urge you to require CMS to halt their finalized PE cut and work with stakeholders to assess facility PE in a systematic way before making such wholesale changes.**

Thank you for your attention to this urgent matter. If you have any questions, please feel free to contact Josh Boswell, Chief Legal Officer at the Society of Hospital Medicine at jboswell@hospitalmedicine.org.

Sincerely,

American Academy of Hospice and Palliative Medicine (AAHPM)
American Academy of Physical Medicine and Rehabilitation (AAPM&R)

American Association of Neurological Surgeons (AANS)
American Association of Orthopaedic Surgeons (AAOS)
American College of Emergency Physicians (ACEP)
American College of Surgeons (ACS)
American Gastroenterological Association (AGA)
American Society of Anesthesiologists (ASA)
American Society of Cataract and Refractive Surgery (ASCRS)
American Society of Echocardiography (ASE)
American Society of Hematology (ASH)
American Society of Plastic Surgeons (ASPS)
American Society of Retina Specialists (ASRS)
Emergency Department Practice Management Association (EDPMA)
Endocrine Society
HIV Medical Association (HIVMA)
Infectious Diseases Society of America (IDSA)
Society of General Internal Medicine (SGIM)
Society of Hospital Medicine (SHM)
Society of Thoracic Surgeons (STS)