Illinois Health and Hospital Association

September 12, 2025

Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1832-P: CY 2026 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Oz:

On behalf of our more than 200 hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) values the opportunity to comment on the calendar year (CY) 2026 Medicare Physician Fee Schedule (PFS) proposed rule. IHA appreciates the Centers for Medicare & Medicaid Services' (CMS) efforts in developing this proposed rule, particularly provisions creating a positive payment update for physicians for the first time in six years, the extension of certain telehealth-related waivers enacted during the COVID-19 public health emergency (PHE), and the continued commitment to expansion and integration of behavioral healthcare services.

However, we are **strongly concerned that the proposed efficiency adjustment to work relative value units (RVU) and changes to practice expense (PE) methodology to decrease facility PE RVUs will inappropriately disadvantage hospital-based practitioners**, who are simultaneously facing instability from significant Medicaid cuts under H.R. 1 in the coming years.[1] In fact, more practitioners are choosing corporate or hospital employment due to the financial risk of independent practice, including underpayments from government and commercial payers. By Jan. 2022, 74% of physicians worked for a corporate or hospital entity, an increase of 12% since 2019 before the PHE. [2] The efficiency adjustment and PE RVU proposals would further exacerbate this financial insecurity, disincentivizing physician practice when we are actively seeking to fill in existing service gaps and attract individuals to the healthcare workforce. We urge CMS to only pursue RVU methodologies that do not unnecessarily disadvantage hospital-based physicians.

[1] Pub. L. No. 119-21, 139 Stat. 72.
[2] Avalere Health. COVID-19's impact on acquisitions of physician practices and physician employment 2019–2021. Apr. 2022. Accessed Sept. 9, 2025. https://www.physiciansadvocacyinstitute.org/portals/0/assets/docs/pai-research/pai%20avalere%20physician%20employment%20trends%20study%202019-21%20final.Pdf

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Telehealth Services

IHA strongly supports the continued extension of telehealth waivers through 2026 and any opportunities to make these policies permanent following several years of successful implementation. Specifically, we support the permanent adoption of the PHE waiver definition of direct supervision. This definition includes virtual presence allowing "immediate availability" of the supervising practitioner via audio/video real-time communications technology for all services described under §410.26, except certain services that have a global surgery indicator. Permanently adopting this definition of direct supervision will empower more practitioners to work at top of license while providing oversight that is critical for patient safety and quality of care. We also support CMS' waiver extension permitting federally qualified health centers and rural health clinics to bill for telehealth services through 2026 in order to continue to address rapidly changing workforce needs, especially in rural areas. We also **strongly support permanently lifting the frequency limits on providing subsequent hospital inpatient and nursing facility visits and critical care consultations furnished via telehealth**. Doing so will reduce unnecessary access and administrative barriers to care and may reduce unnecessary hospitalizations for our most vulnerable patients resulting in better care and cost savings.

However, we are concerned that without further action, practitioners will need to report their home addresses instead of practice addresses next year. **IHA urges CMS to permanently allow practitioners to report practice addresses instead of home addresses when they perform telehealth services from their home.** This administrative fix ensures practitioner privacy and security, and its continuation is critical in a time when violence targeting healthcare practitioners is on the rise.[3]

We also encourage the agency to reexamine the proposal to end the waiver for teaching physicians to have a virtual presence when billing for services furnished involving residents. Evidence was not provided detailing why virtual supervision, which has been allowed for several years, has not adequately met standards within section 1842(b)(7)(A)(i)(I) of the Social Security Act. This section requires teaching physicians to provide appropriate oversight and personal involvement in resident-furnished services. If virtual supervision is not interpreted as meeting this standard in any circumstance within Metropolitan Statistical Areas (MSA), it may be difficult to meet supervision needs with workforce shortages affecting both the healthcare and higher education sectors of the economy.[4] We applaud the flexibility provided to permit teaching physicians to continue to use audio/video real-time communications technology to

[3] Cammie Chaumont Menendez et al. Prioritizing our Healthcare Workers: The Importance of Addressing the Intersection of Workplace Violence and Mental Health and Wellbeing. U.S. Centers for Disease Control and Prevention, NIOSH Science Blog, May 29, 2024. Accessed Sept. 9, 2025. https://blogs.cdc.gov/niosh-science-blog/2024/05/29/hcw_violence_mh/

[4] American Hospital Association. 5 Health Care Workforce Shortage Takeaways for 2028. Accessed Sept. 9, 2025. https://www.aha.org/aha-center-health-innovation-market-scan/2024-09-10-5-health-care-workforce-shortage-takeaways-2028

meet presence requirements outside of MSAs, and we request the same flexibility continue to be permitted within MSAs which face their own unique workforce challenges.

Behavioral Health

IHA has long supported policies that enable behavioral health service integration with physical health services. However, we also recognize that overly specific documentation and other administrative requirements present a persistent barrier to clinical implementation. Given these concerns, **we strongly support the proposal to create three optional add-on codes to advanced primary care management (APCM) services and eliminate existing time-based requirements for behavioral health integration and psychiatric collaborative care model services**. Reducing the documentation requirements for billing and permitting auxiliary personnel to deliver care management services under supervision of the billing practitioner provides an opportunity to expand access to behavioral healthcare and prevent unnecessary hospitalizations.

We also support CMS' timely coverage expansion of digital therapeutics to include devices that treat attention deficit hyperactivity disorder (ADHD). Digital therapy interventions have been found to significantly improve symptoms of ADHD patients, like inattention and decreased reaction time.[5] These effective, non-pharmacological strategies can also help improve cognitive functions, like short-term memory in older adults, in a way that is easy for patients living in rural areas or with transportation barriers to use and for providers to monitor progress.

Dr. Oz, thank you again for the opportunity to comment on the CY 2026 Medicare PFS proposed rule. Please direct questions or comments to Lia Daniels, Senior Director, Health Policy and Finance at ldaniels@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association

[5] Xin Liu et al. The effect of digital interventions on attention deficit hyperactivity disorder (ADHD): A meta-analysis of randomized controlled trials. Journal of Affective Disorders, Volume 365, Nov. 24, 2024, Pages 563-577, ISSN 0165-0327. Accessed Sept. 9, 2025. https://www.sciencedirect.com/science/article/abs/pii/S0165032724013910