



September 12, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1832-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Via online submission at <https://www.regulations.gov/document/CMS-2025-0304-0009>

Re: CMS-1832-P – 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

Dear Administrator Oz,

The Ambulatory Surgery Center Association (ASCA) submits the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed CY 2026 payment policies under the Medicare Physician Fee Schedule (PFS).

ASCA represents the interests of the more than 6,500 Medicare-certified ambulatory surgical centers (ASC) nationwide. ASCs offer a high-quality, convenient and low-cost choice for Medicare beneficiaries who do not require hospitalization after surgical or diagnostic procedures. We appreciate the opportunity to comment on proposed PFS policies that affect ASC clinicians and the Medicare patients they serve.

Physician Conversion Factor

ASCA is pleased to support CMS proposed CY 2026 conversion factor (CF) of \$33.4209 for nonqualifying alternative payment model (APM) clinicians, an increase of 3.32 percent over the CY 2025 CF. While the positive CF adjustment for 2026 is a welcome relief from multiple years of cuts, the positive adjustment is largely due to the one year, 2.5 percent increase passed as part of the One Big Beautiful Bill Act (OBBBA)¹. Given this fact, and the continued adjustment to

¹ <https://www.congress.gov/bill/119th-congress/house-bill/1/text>

other reimbursement factors within the budget neutral PFS payment system, clinicians cannot rely on sustained CF increases beyond 2026.

Understanding CMS' limited ability to address the statutory budget neutrality that has caused recent CF reductions, the agency should nevertheless be extremely concerned at the prospect of Medicare beneficiaries losing access to essential health services if future cuts to the physician CF occur. Continued reimbursement reductions on top of inflationary pressures in the healthcare economy put Medicare beneficiaries at risk of losing access to critical surgical procedures.

ASCA urges CMS to work with Congress to ease cuts to physician reimbursement and implement long-term fixes for budget neutrality components of Medicare payment systems.

Updates to Practice Expense Methodology – Site of Service Payment Differential

ASCA appreciates the opportunity to comment on proposed updates to practice expense methodology in PFS rate setting, specifically CMS' proposal to significantly cut the facility practice expense relative value unit (RVU) allocation relative to the nonfacility practice expense (PE) RVU.

To support this drastic policy proposal, CMS points to two factors: utilization patterns of a handful of clinical specialties and trends in clinician employment. Regarding the former, CMS relies heavily on a June 2025 Medicare Payment Advisory Commission (MedPAC) chapter that notes nine specialties in which at least 60 percent of clinicians furnish at least 90 percent of their Medicare services in a facility setting². MedPAC uses these nine specialties to conclude that many clinicians may not maintain an independent office, however, it does not examine the overall volume or utilization between those specialties and all other specialties whose clinicians are furnishing lower proportions of covered services in facility settings. MedPAC explicitly avoids recommending a broad, across-the-board reduction. In the chapter, MedPAC staff writes that any policies “should be targeted towards clinicians who do not pay indirect PE costs,” and that a misapplied policy could “encourage practices that are independent but provide services primarily in hospitals to financially integrate with a hospital.” Historical data regarding physician employment and the utilization patterns of a handful of specialties does not meet requisite justification for a substantial cut to reimbursement across all clinicians who operate in facilities.

All clinicians, regardless of their predominant site of service or their employment, carry some level of indirect practice expense. Performing services in a facility setting does not mean that indirect costs do not exist; rather, many surgical specialties may experience additional indirect costs that come from staff support (for scheduling, billing, coding and general office roles),

² <https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/>

technology costs and costs for evaluation or follow-up services that are bundled into a global surgical payment that is not eligible for stand-alone nonfacility reimbursement. In fact, these costs are rapidly rising due to rising wages, rents and technology costs. While the exact level of indirect practice expense cost might differ across clinicians, a 50 percent cut to the indirect practice expense allocation for all facility-based procedures risks severe unintended consequences.

As an example, cataract removal surgery (HCPCS 66984) is the highest volume Medicare code performed in surgery centers and a procedure particularly vulnerable to adverse effects from this policy. ASCs perform more than 1.1 million cataract removals every year, accounting for roughly 80 percent of the Medicare volume. By comparison, physician offices perform less than 2 percent of Medicare cataract removals; in fact, in the CY 2023 MPFS final rule CMS joined the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (referred to as the RUC) and the ophthalmic specialty organizations in declining to establish nonfacility values for cataract surgery. The agency emphasized clinical and regulatory consensus around the facility setting as the most optimal site of service for surgery³. Cataract surgery is coded using a 90-day global period, meaning additional surgery or follow-up care has been priced into the current RVU valuation and not billed separately. Ophthalmologists count on indirect practice expense allocation to maintain office space, administrative staff, technology, etc. These elements are essential to a successful cataract removal surgery, but the proposal put forth in this proposed rule has deemed them duplicative. Of course, while cataract removal surgery is an illuminating example it is not the only procedure that may experience these effects. Currently, Medicare pays for 4,200 global procedures with 10- or 90-day global periods, with nearly all these procedures including at least one postoperative evaluation and management (E/M) visit.

For those reasons, ASCA strongly opposes the proposed reduction to facility practice expense RVUs. CMS should gather more data on practice patterns and employment in conjunction with clinician organizations before making any adjustments to the indirect practice expense methodology. A more nuanced approach to delineating facility versus nonfacility expenses is essential to maintain beneficiary access to services and preserve the solvency of physician practices.

Proposed Efficiency Adjustment

ASCA appreciates CMS' commitment and concern regarding code valuation accuracy and understands that significant time can pass between a code's work RVU evaluation by the RUC. However, ASCA has substantial concern regarding the proposal to implement a 2.5 percent cut to the work RVUs for 8,960 non-time-based services. This is justified in the proposed rule as an

³ <https://public-inspection.federalregister.gov/2022-23873.pdf>

efficiency adjustment to mitigate CMS’ perceived overvaluation of intraservice time relative to empirical intraservice time as part of the physician time and work RVUs.

As evidence of potential inaccuracies in work RVUs, CMS cites two major factors. The first factor is the process of the RUC valuation, which partially relies on clinician survey data as an indication of time needed to perform services. CMS expresses concern regarding RUC survey response rate, as well as the time that passes between RUC evaluations for each code. CMS estimates an average of 17.69 years between RUC review for the average code; however, the agency did not differentiate for utilization when making that estimation. A McDermott+ analysis found that high-volume codes (codes in the top 10 percent of volume) are evaluated roughly every 11 years⁴. The longer average review timeline across all codes is likely skewed by low-volume codes that are difficult to accumulate in large, accurate samples.

CMS also references two studies as justification of the overvaluation of procedure time, including a pilot project conducted by the Urban Institute in 2016. This pilot found that fee schedule time was inflated relative to empirical data. However, the pilot was never intended to prove time inconsistencies in the work RVUs themselves; rather, the authors state that the pilot was designed to “provide CMS with a process for reviewing proposed work RVUs.”⁵ The second study, which found that average estimated procedure times are roughly 27 percent shorter than the times used in RVU evaluation, noted that the time discrepancy varied heavily by code and specialty. The authors noted that some CPT codes and specialties “equaled or exceeded the valuation time,” and that “older patients and those with more illness had longer procedure times.” To use this research as justification for an across-the-board cut to the work RVUs of thousands of codes is a clear misapplication of the authors findings, and one that may even contradict their efforts to improve RVU time evaluation.

Recent research contradicts CMS’ assumption that all procedures are becoming more efficient over time. A research letter published by the Journal of the American College of Surgeons analyzed data from 1.7 million procedures across 249 CPT codes, comparing operative times between 2019 and 2023. The analysis found that operative times increased in the study period for 51.4 percent of codes, with an average operative time increase of 3.1 percent across all codes⁶. The authors note that several factors might contribute to this, including a nonlinear efficiency progression for junior surgeons, the ability to expand patient eligibility for surgery due to modern techniques and recovery protocols, and an aging population that is undergoing surgery more frequently than previous generations.

⁴ <https://www.mcdermottplus.com/insights/cms-proposes-productivity-based-adjustment-to-physician-work-values-for-cy-2026/>

⁵ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Collecting-Empirical-Physician-Time-Data-Urban-Report.pdf>

⁶ https://journals.lww.com/journalacs/abstract/9900/longitudinal_trends_in_efficiency_and_complexity.1369.aspx

CMS' proposal to use a cumulative Medicare Economic Index (MEI) productivity adjustment is a blunt instrument that will suppress rates in a compounding manner if continuously applied every three years as proposed. To support this proposal, CMS notes that an MEI adjustment is already applied annually in the hospital inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS). However, the application of the MEI adjustment in those payment systems is fundamentally different from the proposal asserted in this year's PFS proposed rule. Both the IPPS and OPPS receive an annual inflationary update to their conversion factors, which is then subsequently adjusted by the MEI productivity factor. Thus, hospital outpatient departments paid under the OPPS are still set to receive a proposed 2.4 percent effective payment update to the OPPS conversion factor even after the application of the 0.8 percent productivity adjustment⁷. No annual inflation adjustment exists in the PFS, and this proposal would directly affect the fundamental code valuation by altering the work RVU itself. This means that over time, the work RVUs for thousands of codes would be continually adjusted downward without regard for changes in the physician workforce, patient population or practice patterns. ASCA agrees that providers can often develop more efficient workflows with greater expertise but adjusting payment negatively both across-the-board and in perpetuity will have an adverse effect on physician ability to perform procedures and negate the very gains in efficiency that CMS is recognizing in the first place.

Additionally, the proposed adjustment to work RVUs would occur simultaneously to other changes within the PFS that would have compounding detrimental effects on certain specialties. For example, the Society for Cardiovascular Angiography & Interventions (SCAI) analyzed the cumulative effect of RUC reevaluations proposed cuts to the facility indirect practice expense and the proposed efficiency adjustment to work RVUs. For one procedure, left atrial appendage closure (CPT 33340), the cumulative effect is a 35 percent reduction in reimbursement by 2027. McDermott+ also performed an analysis of cumulative code-level adjustments and found 18 codes that would be directly affected by the proposed efficiency adjustment and work RVU cut⁸. Thirteen of the 18 twice-affected codes would see an immediate cut in reimbursement greater than 10 percent. As an example, a prostatectomy (HCPCS 52601) would see a decrease in reimbursement of 26 percent in 2026 relative to 2025. This procedure is performed roughly 30,000 times per year in hospital outpatient departments. Reimbursement cuts of this magnitude will almost certainly reduce beneficiary access.

For these reasons, ASCA strongly opposes the proposed negative 2.5 percent efficiency adjustment. ASCA does not support the use of the five-year look-back period as an accurate adjustment to any PFS services. Until other portions of the PFS, namely the conversion factor

⁷ <https://www.federalregister.gov/documents/2025/07/17/2025-13360/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical>

⁸ <https://www.mcdermottplus.com/insights/twice-targeted-codes-affected-by-both-work-rvu-updates-and-new-efficiency-adjustment-in-the-cy-2026-pfs-proposed-rule/>

and updates to practices expense inputs are stabilized, ASCA does not support any further adjustments related to physician time inputs.

Strategies for Improving Global Surgery Payment Accuracy

ASCA appreciates CMS' commitment to refining the valuation of the global surgical packages within the physician fee schedule. Before commenting on the specific proposals in this year's rule, ASCA must reiterate its advocacy for CMS to apply RUC-recommended updates to office/outpatient E/M codes furnished as part of a global surgical package. While ASCs do not receive a technical payment for E/M services furnished under Medicare and these visits are seldom performed in ASCs, E/M services are an essential part of the pre- and postoperative process and have a direct relationship to optimal patient and procedure referral.

The RUC, which represents all medical specialties, voted overwhelmingly (27–1) in April 2019 that full RVU increases should be incorporated into global code packages⁹. More recently, the RUC recommendations for CY 2025, as outlined in an October 2023 letter to Administrator Brooks-LaSure, include the recommendation that CMS apply E/M updates to those services included in the global package¹⁰. The surgical provider community also has been united in recommending that CMS incorporate revised E/M values into visits bundled as part of global surgical packages. Failure to update payments for certain E/M codes creates unfair payment differences between surgical specialties and other physician types for providing the same services. For these reasons, ASCA again requests that CMS incorporate recent E/M coding updates to visits furnished as part of global surgical packages.

Procedure Shares within Global Surgical Packages

ASCA appreciates CMS' desire to ensure that payment for 90-day global surgical packages accurately reflect the care delivered by each provider in the global period.

In comments responding to the CY 2025 PFS proposed rule, ASCA expressed concerns for the transfer of care modifier policy, citing potential inaccuracies in global package valuation and potential logistical issues in Medicare Administrative Contractor (MAC) claims processing tied to informal or undocumented transfers of care. Other surgical specialty organizations also noted the difficulty in assigning care responsibility when a surgical service involves coordination from a team of clinicians, including complex postoperative care.

ASCA will defer specific comment on the three proposed scenarios for assigning procedure shares as part of global surgical packages to the specialty organizations. ASCA encourages CMS

⁹ <https://www.ama-assn.org/system/files/2019-07/ruc-voting-office-visits-final.pdf>

¹⁰ <https://www.ama-assn.org/system/files/oct-2023-ruc-recommendations.pdf>

to work with the RUC and the surgical specialty organizations to formulate the most accurate valuation for surgical care delivery.

Proposed Ambulatory Specialty Model

ASCA appreciates the opportunity to comment on the proposed Ambulatory Specialty Model (ASM). In comments responding to the CY 2025 Medicare PFS proposed rule, ASCA expressed concerns about implementing a new value-based payment model given the instability occurring within the PFS payment system. ASCA also cited the short potential implementation timeline and strict health IT requirements as factors in not supporting the proposed MIPS Value Pathways (MVP)-type payment framework aimed at ambulatory specialty care.

While appreciating the obvious time and effort that CMS and the Centers for Medicare & Medicaid Innovation (CMMI) have put into developing the ASM proposal, many of the concerns noted in last year's rule persist. ASCA provides the following responses to selected comment areas within the ASM proposal and looks forward to continuing discussions about the appropriate metrics and levers that can deliver Medicare beneficiaries the highest quality, most cost-effective care.

Proposed Length of Model Test

ASCA expressed concerns regarding a potential specialty model start date of January 1, 2026. The proposed ASM start date of January 1, 2027, still represents a rapid implementation timeline and ASCA urges CMS to consider delaying the model start date further, depending on the readiness of the clinical specialties involved.

Proposed Mandatory Participation

ASCA has serious concerns with any model design that requires mandatory participation for clinicians. CMS has yet to complete the transition from traditional MIPS to MVP reporting; although clinicians will be familiar with the general MIPS performance categories being used in the ASM model, many might not yet have exposure to reporting under a cohesive, specialty-focused measure set. Research published in the *Journal of the American Medical Association* found that compliance with existing MIPS requirements costs physicians \$12,800 and involves 53 hours of work per year¹¹. Although the ASM model is built upon the MVP framework, it differs notably in the required measure set and performance scoring calculation that will ultimately affect reimbursement. Compliance with this new framework is certain to increase the time and cost burdens and might have negative care consequences antithetical to the agency's goals of accurately assessing clinical processes, care coordination and patient outcomes.

¹¹ <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947>

ASM Specialty Identification

The use of specialty codes on clinician claims to identify ASM model participants would seem to be the most straightforward mechanism to identifying clinicians. However, ASCA suggests that CMS/CMMI consider identifying clinicians who have a relevant specialty type on the majority of their claims rather than a simple plurality. This alternative approach could prevent some clinicians with relatively low procedure volume in the ASM specialties from being included in the model and therefore being subject to the potential payment effects.

Proposed Quality ASM Performance Category

As previously noted, compliance with existing MIPS requirements creates significant time and cost burdens for eligible clinicians. While mandating reporting for all measures within the specialty set in the ASM Quality performance category will allow for more accurate comparisons, it might also create significant and unequal burdens. In a traditional MVP framework, clinicians have the flexibility to select measures from a pool in their quality performance category. Under this proposed ASM framework, clinicians must report all quality measures in their ASM measure set. Given the mandatory participation of the ASM model itself, giving clinicians flexibility in quality measure reporting will ease the burden of model participation while maintaining ample points of comparison.

ASM Promoting Interoperability Performance Category

ASCA recognizes that promoting the growth of health IT and the widespread use and seamless transfer of electronic health information is a core goal for CMS/CMMI. However, ASCA has significant concerns regarding the proposed requirements of the ASM Promoting Interoperability (PI) performance category.

ASCA reminds CMS that ASC-based clinicians are eligible for automatic reweighting of the traditional MIPS PI performance category due to the federally recognized lack of electronic health record (EHR) technology in surgery centers¹². While ASCs represent the leading edge of outpatient surgical techniques, EHR and health IT adoption lags other facility types. As recently as 2020, estimates from ASC EHR vendors put overall EHR penetration in surgery centers at 15 to 20 percent. While the proportion has increased in recent years, ASCA continues to estimate that, at most, 50 percent of surgery centers use an EHR. Additionally, some facilities that use an EHR are likely using a product ill-suited to their clinical needs and processes. For comparison, data from the Assistant Secretary for Technology Policy/Office of the National Coordinator for

¹² See Section 16003 of the *21st Century Cures Act*, which exempts ASC-based clinicians from penalties under Meaningful Use

Health IT shows that hospitals achieved 90 percent EHR adoption and physician offices achieved 74 percent EHR adoption by 2014¹³.

Some aspects of low EHR uptake can be attributed to choice. ASCs tend to be small businesses that operate with a small staff and thin margins, and many centers do not have the financial means or staffing capability necessary for procurement, implementation and ongoing operation of an EHR. Conversely, even larger facilities with relatively more financial and/or staffing capabilities find implementation to be overly complex due to the intricate nature of their needs. Given this environment, ASC-based clinicians will be less equipped to succeed in a model whose design relies on health IT, much less certified EHR technology (CEHRT), compared to their counterparts who practice predominantly in hospitals and physician offices.

Recent ASCA surveys on health IT reveal the potential difficulties that facilities experience when incorporating EHRs into their operations. A July 2025 survey of ASCA members found that even surgery centers currently using an EHR have ongoing concerns about integration with external systems. Among 203 surgery centers that reported use of an EHR, 43 percent stated concern regarding their ability to connect to external programs and 40 percent stated concern regarding the ability to send and receive patient information¹⁴. An August 2024 survey of 321 surgery centers found that only 54 percent were using an EHR to facilitate reporting to Medicare's ASC Quality Reporting (ASCQR) program. Clearly, additional time and investment is necessary before CMS can rely on health IT to provide an accurate depiction of clinical decision making and patient care in surgery centers.

The lack of an exception or special status on CEHRT requirements for ASM participants might skew the accuracy of fundamental comparisons that the ASM model is attempting to create. For some clinicians it will simply not be feasible or practical to procure and implement CEHRT in their practices. Without an exception or special status these clinicians will be forced to accept an ASM performance score without the PI performance category or, in extreme cases, stop accepting Medicare patients altogether. CMS' stated concern that providing flexibility in PI CEHRT reporting may disincentivize CEHRT adoption does not consider the reality that the clinician relationship to CEHRT contains a multitude of factors above Medicare value-based payment reporting.

ASCA staff maintain a collaborative relationship with staff at the ONC Office of Policy and continue to advocate for ASC-specific standards and maximum regulatory flexibilities. A group of ASCA-affiliated EHR vendors hold occasional roundtable calls with ONC to ensure the most up-to-date, compliant products are available to ASCs and to educate ONC staff on the unique

¹³ <https://www.healthit.gov/data/quickstats/national-trends-hospital-and-physician-adoption-electronic-health-records>

¹⁴ ASCA 60-Second Survey, July 2025

nature of ASCs compared to hospitals and physician offices. These relationships can provide the foundation for further discussions between CMS, ONC and ASCA on the proper incorporation of health IT and electronic data collection within the proposed ASM model.

ASCA strongly advocates for the continuation of special status designation for ASC-based clinicians in a prospective ambulatory care model.

Transition from Traditional MIPS to MVPs

In previous comments, ASCA expressed broad support for the MVP framework. Given that traditional MIPS just reached maturity in 2022, ASCA advocated for an extended transition from traditional MIPS to mandatory MVP reporting. CMS should closely monitor reporting of MVPs during the transition and be mindful of clinician burden under the new quality reporting structure. ASCA will defer comments on specific MVP proposals to clinicians and specialty organizations.

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ASCA appreciates CMS' acknowledgement that all settings of care and practices of all sizes are essential to providing high-quality, efficient care to Medicare beneficiaries. We value the agency's willingness to listen to our concerns as we strive to support our members in providing high-quality patient care and look forward to continuing to work with you and your staff. If you have any questions, please contact Kara Newbury at knewbury@ascassociation.org or 703.636.0705.

Sincerely,



William Prentice
Chief Executive Officer