



September 14, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1848-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Via online submission at <https://www.regulations.gov/document/CMS-2026-2377-0002>

Re: 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

Dear Administrator Oz,

The Ambulatory Surgery Center Association (ASCA) submits the following comments in response to the Centers for Medicare & Medicaid Services' proposed CY 2027 payment policies under the Medicare Physician Fee Schedule (PFS).

ASCA represents the interests of the more than 6,600 Medicare-certified ambulatory surgical centers (ASCs) nationwide. ASCs offer a high-quality, convenient and lower-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 reiterates concerns noted in previous comment letters regarding consistent, negative adjustments to the physician conversion factor (CF). The positive 2026 CF was a welcome relief after five consecutive years of negative CF adjustments, decreases that were only protected from more serious declines thanks to congressional action. The agency should be extremely concerned at the prospect of Medicare beneficiaries losing access to essential health services if cuts to the physician CF persist. Continued reimbursement reductions on top of inflationary pressures in the healthcare economy put Medicare beneficiaries at risk of losing access to critical surgical

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

Proposal to Remove Indirect Practice Cost Index from Practice Expense RVU Calculation Methodology

ASCA has concerns regarding CMS' proposal to remove the steps of the indirect practice expense (PE) calculation methodology that rely on the indirect practice cost index (IPCI) data. Despite CMS' assertion that continued reliance on data from the 2007 Physician Practice Information (PPI) Survey may be misrepresenting current practice expense estimates, simply removing IPCI data from the methodology and instituting a 5% year-over-year limit is not a reasonable remedy.

CMS reiterated in the CY 2026 PFS proposed rule that the agency believes that "the [PPI Survey] is the most comprehensive source of PE survey information available."¹ Given this fact, the most reasonable solution to updating the 2007 survey data would be to implement the updated PPI Survey data that was collected by the American Medical Association (AMA) and Mathematica from 2023 to 2024. This survey was issued with the support of more than 170 organizations, including all state medical associations and more than 100 specialty societies and other professional associations.²

In its comment letter on the CY 2026 PFS proposed rule, the AMA responded to numerous concerns raised by CMS with regard to the accuracy and completeness of PPI Survey data.³ This includes agency concerns regarding survey sample size, response rate, measurement error and much more. ASCA agrees with the AMA that the 2024 PPI Survey data is the most complete and accurate representation of specialty practice costs available and should be a sufficient foundation for replacing the current IPCI data in the indirect PE methodology.

ASCA opposes the proposal to implement a 5% limit on PE RVU changes year-over-year in lieu of updated PPI Survey data. The 5% limit will not protect codes from large valuation changes in the long term, and many specialties could see major effects even if year-over-year volatility is mitigated. For these reasons, ASCA does not support the proposed phaseout of the IPCI from the calculation of PE RVUs and strongly urges CMS to work with the AMA to find ways to implement 2024 PPI Survey data in PE RVU calculations for future years.

¹ <https://public-inspection.federalregister.gov/2025-13271.pdf>

² <https://www.ama-assn.org/system/files/support-letter-medicare-ppi-survey.pdf>

³ <https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lmpfs.zip/2025-9-11-Letter-to-Oz-re-CY26-MPFS-v3.pdf>

Updates to Practice Expense Methodology—Site of Service Payment Differential

ASCA reiterates strong opposition to the site of service payment differential policy, which allocates half the amount of indirect RVUs for services performed in the facility setting relative to those same services performed in the non-facility setting.

In its CY 2026 PFS proposed rule comment letter, ASCA challenged the elements used to support this drastic policy proposal, namely, the use of historical data on a handful of specialties to justify 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), technology costs, and costs for evaluation or follow-up services that are bundled into a global surgical payment that is ineligible for standalone non-facility reimbursement. A 50% cut to the indirect practice expense allocation for all facility-based procedures is a harsh and unnecessary policy, one that is certain to reduce the availability of ASC-based specialists for Medicare beneficiaries.

One such procedure harmed by this policy is cataract removal surgery (HCPCS 66984)—the highest volume Medicare code performed in surgery centers. ASCs performed 1.2 million cataract removals in 2024, roughly 80% of all Medicare volume.⁴ CMS has consistently asserted its belief, shared by the AMA Specialty Society Relative Value Scale Update Committee (RUC) and ophthalmic specialty organizations, that a facility setting is the optimal site of service for cataract removal surgery.⁵ 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 this proposed rule has deemed them duplicative.

According to a 2021 survey of members by the American Academy of Ophthalmology, only 18% of responding ophthalmologists reported being employed by a hospital/health system or an academic institution. Among respondents, 74% were employed in solo or group ophthalmic practice, and their ability to maintain a practice site separate from their surgical setting is being directly harmed by the site of service policy.⁶ Other specialties with procedures commonly performed in surgery centers similarly have high proportions of clinicians employed in private practice; AMA's 2024 Physician Practice Benchmark Survey found that 54% of orthopedic surgeons were employed in private practice.⁷ Despite this high proportion of private practice, the nature of orthopedic surgery requires surgeons to perform a majority of their Medicare services in facility settings. For example, physician offices are not equipped or regulated to perform total

⁴ ASCA analysis of CMS 2024 PSPS data

⁵ <https://public-inspection.federalregister.gov/2022-23873.pdf>

⁶ <https://www.aao.org/eyenet/article/snapshot-ophthalmology?july-2026>

⁷ <https://www.ama-assn.org/practice-management/private-practices/smaller-share-doctors-private-practice-ever>

joint replacements. CMS' own projections in the CY 2026 PFS proposed rule estimated that facility-based orthopedic surgical services would see payment cuts of -9%. A recent analysis by KNG Health projected that performance of orthopedic surgeries in ASCs will save Medicare \$13.5 billion during the period from 2025 to 2034.⁸ However, these savings will be unrealized if orthopedic surgeons face drastic cuts to their reimbursements that cannot be offset by commensurate increases in non-facility services. Ultimately, the growing and aging population of Medicare beneficiaries will find reduced access to essential surgical procedures like total joint replacements.

CMS should suspend the site of service payment differential policy pending further data on physician practice patterns and employment. A more nuanced approach to delineating facility versus non-facility expenses is essential to maintain beneficiary access to services and preserve the solvency of physician practices.

Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems: Global Surgical Packages

ASCA supports CMS' commitment to refining the valuation of global surgical packages within the PFS. ASCA continues to echo the AMA and all major surgical specialty organizations in requesting that CMS apply RUC-recommended updates to office/outpatient evaluation and management (E/M) codes furnished as part of global surgical packages. 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. 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.

ASCA supports CMS' proposal to pause data collection based on reporting of CPT code 99024. The Department of Health and Human Services Office of Inspector General (OIG) issued a report in June 2025 that found significant flaws in CMS data collection regarding postoperative visits. OIG found that the data for more than 40% of the global surgery samples "were inaccurate and cannot assist in improving global surgery valuation as Congress intended."⁹ Another OIG report released in August 2025 found that 93% of global surgery samples did not reflect the actual number of postoperative visits. In its reports, OIG points out significant, fundamental flaws in the reporting of postoperative visits using CPT code 99024, including lack of provider education on CMS policy, inadequate billing system capabilities and lack of access to medical records.

⁸ <https://www.ascassociation.org/asca/about-ascs/savings/medicare-savings-from-use-of-ambulatory-surgery-centers>

⁹ <https://oig.hhs.gov/documents/audit/10428/A-05-20-00021.pdf>

ASCA does not support expansion of requirements related to billing CPT code 99024 for the purpose of refining postoperative visit valuation in global surgical packages. The OIG report includes several recommendations that can be taken toward developing a better understanding of postoperative visit practice patterns, which CMS can develop and implement with the input of specialty organizations that frequently bill global procedures.

Proposed Work RVU Amounts for Total Joint Replacements

ASCA has serious concerns about the work RVUs proposed for total joint surgeries, specifically CPT codes 23470, 23472, 27130 and 27447. CMS asserts that these codes have a “site of service anomaly,” or an indication that these codes are performed less than half the time in inpatient settings despite including inpatient hospital E/M values. The RUC had already recommended reducing work RVU values for these services by roughly 10%, but CMS is proposing a more drastic reduction that would reduce work RVU values by 15-20%. In combination with other policies in the PFS, this equates to a 27.5% cut to total joint replacement physician reimbursement rates in just two years, according to the American Association of Hip and Knee Surgeons.¹⁰ These latest cuts exacerbate reimbursement trends that were already failing to keep pace with inflation; according to a 2025 article published in *The Journal of Arthroplasty*, reimbursement for primary total knee arthroplasty decreased by 57% from 2000 to 2024 when adjusting for inflation.¹¹

ASCA disagrees with CMS regarding the justification for the work RVU values below those recommended by the RUC. A reduction in intraservice time does not necessarily mean that less work was performed; rather, the same work is still being performed with greater efficiency and intensity. Additionally, the migration of these procedures from inpatient to outpatient settings has no direct relationship to the work, risk or complexity of the physician performance of the procedure itself. The essential steps required for a successful surgery remain the same regardless of whether the procedure is being performed in an inpatient or outpatient operating room, and the physician should not be penalized for greater availability of outpatient sites of service.

These cuts to reimbursement rates will undoubtedly cause declining availability of these procedures for Medicare beneficiaries during a period when there will be more demand than ever from an aging beneficiary pool. Although total joint replacement procedures are categorized as elective surgeries, they provide meaningful improvements to patient mobility and independence and can prevent progression of painful joint diseases such as osteoarthritis. Understanding CMS’ desire to value services accurately as they become efficient and widely available, the reductions to work RVU values below RUC recommendations are unwarranted and harmful to Medicare beneficiaries.

¹⁰ <https://www.aahks.org/wp-content/uploads/2026/08/AAHKS-Member-Brief-on-CMS-proposed-cuts-08.19.26.pdf>

¹¹ [https://www.arthroplastyjournal.org/article/S0883-5403\(25\)00371-7/abstract](https://www.arthroplastyjournal.org/article/S0883-5403(25)00371-7/abstract)

Accounting for E/M Resource Overlap Between Standalone Visits and Global Periods

In comments submitted on the CY 2019 PFS proposed rule,¹² ASCA aligned with the provider community in strong opposition to the multiple procedure payment reduction (MPPR) proposal that would have reduced payment by 50% for the least expensive procedure that the same physician (or group practice) furnished on the same day as a separately identifiable E/M visit. CMS ultimately declined to implement the MPPR, and it's not clear why the policy is being proposed again without any new evidence or justification. CMS does not offer any specific rebuttal to previous arguments made against the proposal such as the existence of modifier -25, the RUC review process, and the potential to disrupt practice patterns and clinician behavior. Perhaps most notably, CMS does not provide any additional rationale for the 50% reduction as opposed to other suggested adjustments.

In the absence of evidence supporting the need for a payment reduction that has the potential to disrupt Medicare beneficiary services and imperil the solvency of physician practices,¹³ ASCA does not support the proposed reduction to separately identifiable office or outpatient E/M visits provided in conjunction with a surgical procedure. CMS should work with the AMA and the RUC to develop an alternative solution with input from provider organizations if the agency believes that duplicative payment is occurring.

Request for Information on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

ASCA recognizes CMS' interest in reducing duplicative Medicare services but does not support any standardized period within which an image or laboratory test should automatically be considered "duplicate." Instituting this policy would suppose too much similarity in patient treatment and creates potential for payment disincentives to interrupt clinical decision-making.

For some specialties commonly practiced in surgery centers, such as gastroenterology and ophthalmology, laboratory testing is used to assist in patient monitoring. For example, a gastroenterologist may appropriately order multiple tests or conduct repeat imaging to monitor disease progression and treatment response. Requiring a specialist to justify each of these circumstances would cause significant additional burden on providers and interrupt beneficiary access to care. For these reasons, ASCA joins numerous specialty organizations in opposing rigid testing intervals and/or payment predicated on predetermined timeframes. CMS should work with specialty organizations to develop proper clinical guidelines and leverage technology to give specialists faster, easier access to previous testing and imaging to reduce duplication.

¹² <https://higherlogicdownload.s3.amazonaws.com/ASCACONNECT/975a33fe-e4b9-41ad-92b4-8f6bbfc25293/UploadedImages/documents/regulatory/medicare/2018/asca-cy19-mpfs-proposed-rule-comment.pdf>

¹³ <https://www.ama-assn.org/about/leadership/50-medicare-pay-cut-would-put-physician-practices-risk>

Proposed Changes to the Ambulatory Specialty Model

In previous comments, ASCA has expressed concerns about the ASM, including the implementation of a new model amidst general payment instability for outpatient specialists, less flexibility with regard to health information technology for small practices and added administrative burden.

Despite the time and effort that CMS and the Center for Medicare and Medicaid Innovation (CMMI) have put into developing the ASM proposal, many of the concerns submitted in response to previous proposed rules persist. ASCA provides specific comments below and strongly urges CMS to delay implementation of the model while the agency works in collaboration with the provider organizations to refine participation and reporting requirements.

Proposed Model Start Date

Last year, ASCA expressed concerns regarding the potential ASM start date of January 1, 2026. The current proposed start date of January 1, 2027, still represents a rapid implementation timeline, especially since CMS has yet to release a final mandatory participant list or conduct meaningful outreach to ensure that participants understand the model requirements. ASCA urges CMS to consider delaying the start date further.

Clinician Participation and Reporting

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, 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 year.¹⁴ Although the ASM 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.

¹⁴ <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947>

The ASM framework unduly focuses on individual clinician performance for beneficiary services that often include an entire care team. The AMA, the American College of Cardiology and the American College of Surgeons have all stated in previous comments that the focus on individual clinician measurement is antithetical to actual care practices and larger objectives surrounding improving care coordination. High payment adjustments that are adjudicated by clinician performance against other model participants creates a competitive environment that disregards the best interests of Medicare beneficiaries. ASCA urges CMS to reevaluate the framework for clinician participation and scoring so that the full spectrum of care is considered and quality meaningfully measured.

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/CMML. However, ASCA must reiterate concerns regarding the reporting requirements of the ASM Promoting Interoperability (PI) performance category.

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 centers.¹⁵ While ASCs are leaders in 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 15-20%. 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 Health IT shows that hospitals achieved 90% EHR adoption and physician offices achieved 74% EHR adoption by 2014.¹⁶ Given this environment, ASC-based clinicians will be less equipped to succeed in a model design that 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 2026 survey of ASCA members found that even surgery centers currently using an EHR have ongoing concerns about integration with external systems. Among 266 facilities that reported using an EHR, 43% stated concern regarding their ability to connect to external programs and 40% stated concern regarding the ability to send and receive patient information.¹⁷ An August 2024 survey of 321 surgery centers found that only 54% were using an EHR to facilitate reporting to Medicare's ASC Quality

¹⁵ See Section 16003 of the *21st Century Cures Act*

¹⁶ <https://www.healthit.gov/data/quickstats/national-trends-hospital-and-physician-adoption-electronic-health-records>

¹⁷ ASCA *60-Second Survey*, July 2026

Reporting 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 is attempting to create. For some clinicians, it is simply not 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. For these reasons, ASCA strongly advocates for the continuation of a special status designation for ASC-based clinicians in a prospective ambulatory care model.

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CMS acknowledges 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