September 12, 2025
Submitted electronically via: http://www.regulations.gov

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CY 2026 Physician Fee Schedule Proposed Rule

Dear Administrator Oz:

The Office-Based Facility Association (OBFA) appreciates the opportunity to offer its comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule for the CY 2026 Physician Fee Schedule (CMS-1832-P).[1] OBFA is a coalition of practitioners and affiliated entities involved in providing office-based interventional care. Many terms are synonymous with "office-based," including "private practice," "freestanding," "nonfacility," or "place of service 11" and such providers often are independent physicians, small businesses, and rural providers. OBFA's vision is for a Physician Fee Schedule that prioritizes payment stability and predictability for office-based interventionalists.[2] This letter offers comments on the following issues:

- Value of Office-Based Interventional Care
- Updates to the Indirect Practice Expense (PE) Methodology
- Use of OPPS data to set PFS rates
- Undervaluation of conversion factor due to G2211 Assumption
- Efficiency Adjustment

I. VALUE OF OFFICE-BASED INTERVENTIONAL CARE

Office-based interventional care is a critical component of the U.S. healthcare system. Such care crosses a wide range of specialties, including cardiology, interventional radiology, pain medicine, physical therapy, proton therapy, radiation oncology, urology, vascular surgery, and more. Each site-of-service has an important role to play in the healthcare continuum with hospitals being best suited for emergent patients and ASCs offering a low-cost surgical alternative to hospitals.

[1] Federal Register, 90 FR 32352, 16 July 2025
[2] For more information about OBFA, please see https://www.obfassociation.org/about-us

However, the office-based setting is inherently the lowest cost site-of-service and critical to providing care in rural and underserved areas where ASCs are not typically present (e.g. due to CON, cost considerations) and where significant specialty deserts exist.[3][4] Figure I shows the key differences between the sites-of-service.

FIGURE I

Hospital	ASC	Office
Most expensive setting	Cost less than hospital	Lowest cost
Emergent capabilities	General sedation	Conscious sedation
Mostly urban	Mostly urban	Urban and rural
All services	Surgical	Minimally-invasive procedures
	CoN restrictions	*Preventative Gateway for Care: Clinic Visits, Diagnostics, Procedures*

II. UPDATES TO PRACTICE EXPENSE (PE) METHODOLOGY – SITE OF SERVICE PAYMENT DIFFERENTIAL

As noted above, many terms are synonymous with "office-based," including "private practice," "freestanding," "nonfacility," or "place of service 11" and such providers often are independent physicians, small businesses, and rural providers. In the 2026 PFS Proposed Rule, CMS notes strong concern relating to the collapse of private practice, stating:

- [T]rends indicate a steady decline in the percentage of physicians working in private practice, with a corresponding rise in physician employment by hospitals; and growth in the percentage of physicians who practice exclusively, or almost exclusively, in the facility setting. When the PFS was established, the methodology for allocating indirect practice expense was based in part on an assumption that the physician maintained an office-based practice even when also practicing in a facility setting. In that context, the PE methodology

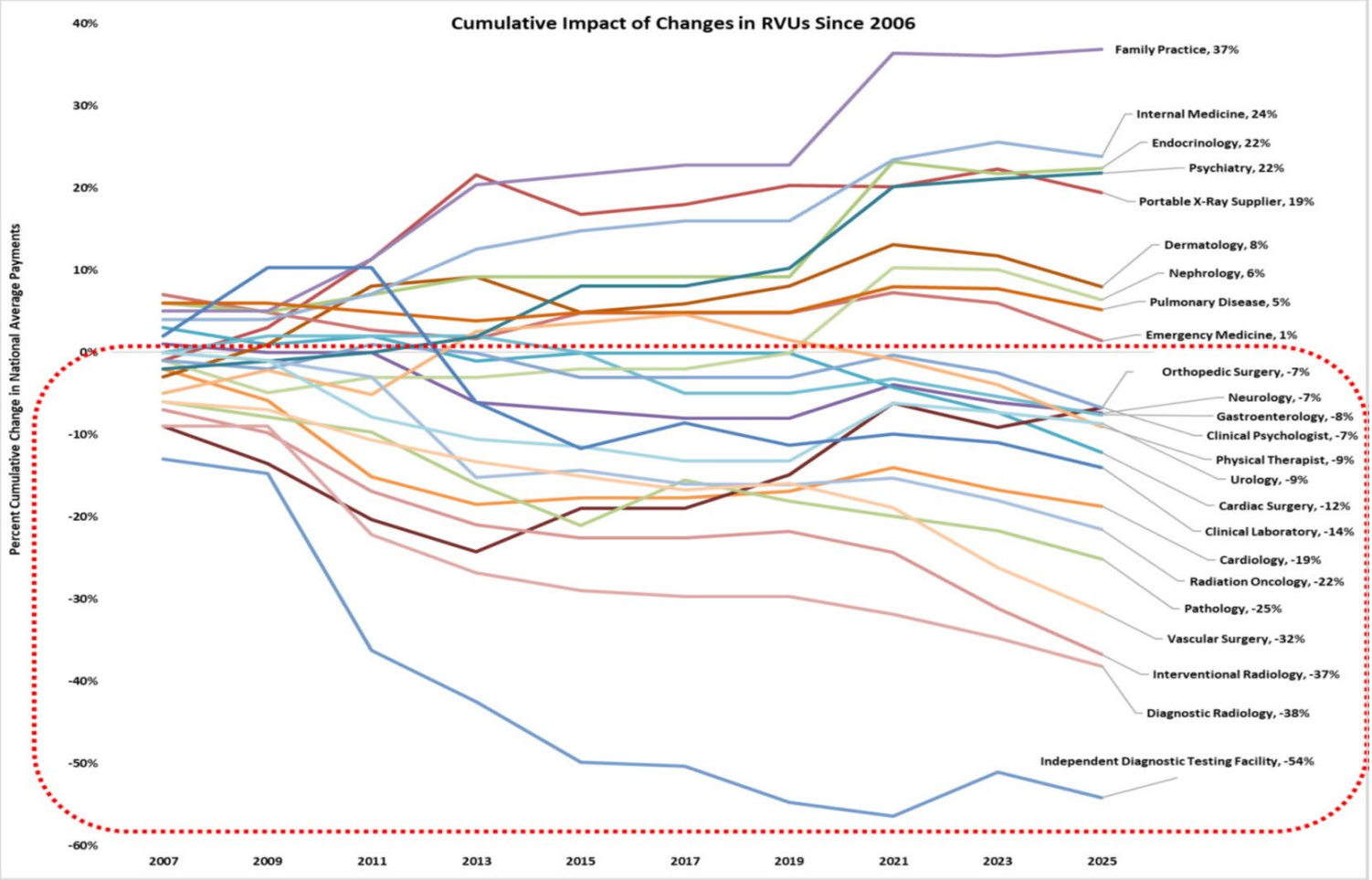
[3] For a more detailed primer on office-based interventional care, see here: https://www.obfassociation.org/_files/ugd/4d8e3a_bca766bc31054e5e9c41d5e503eda505.pdf
[4] For a review of specialty deserts, see here: https://www.obfassociation.org/interventionalanddiagnosticproviderdeserts

has allocated the same amount of indirect costs per work RVU, without regard to setting of care.

- We share MedPAC's concerns regarding the potential for duplicative payment under the current PE methodology for allocating indirect costs for physicians practicing in the facility setting. Allocating the same amount of indirect PE per work RVU for services furnished in the facility setting as the nonfacility setting may no longer reflect contemporary physician practice trends.
- For these reasons, for each service valued in the facility setting under the PFS, we are proposing to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to nonfacility PE RVUs beginning in CY 2026.

For office-based interventional providers in particular, cuts since 2006 have been upwards of 20 – 40% or more (see Chart I).[5]

CHART I

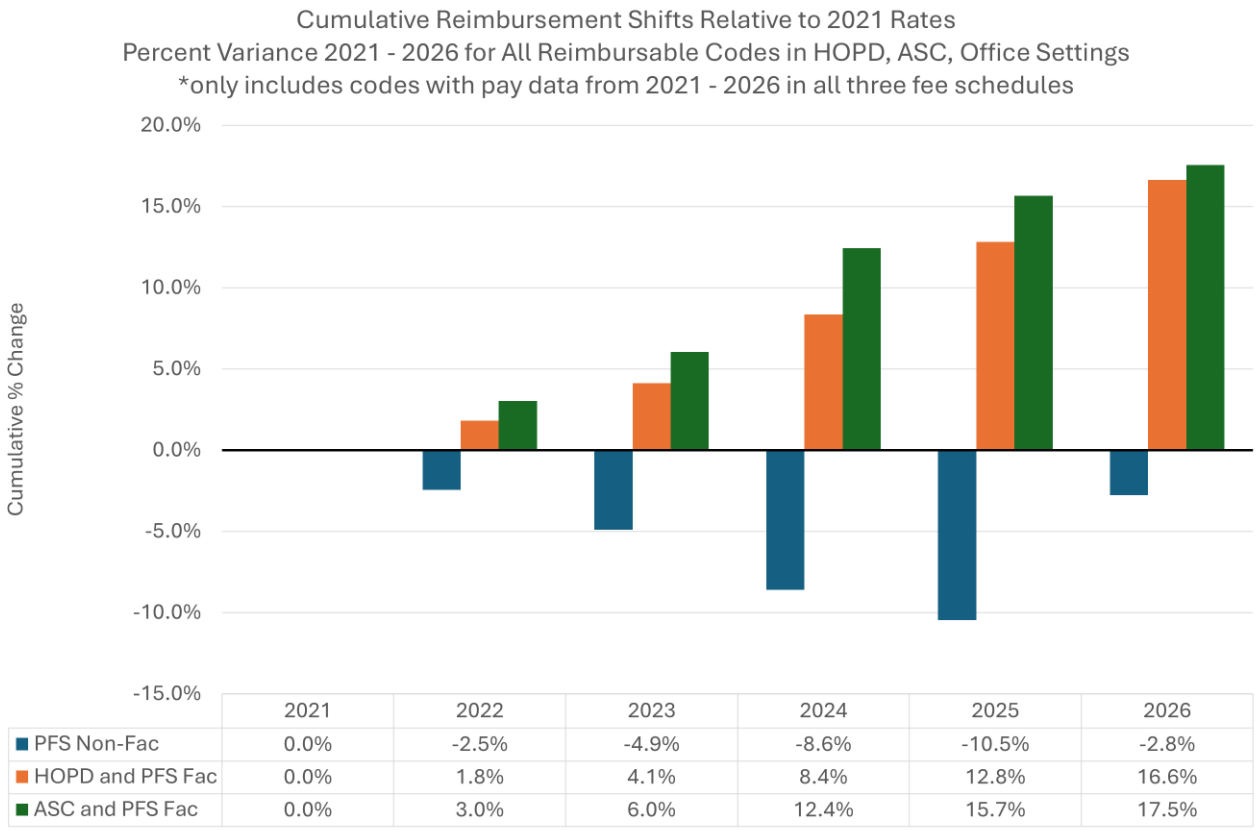


Fortunately, due in part to the proposed update to the PE methodology, the 2026 PFS Proposed Rule marks the first meaningful improvement for office-based (i.e. non-facility) providers in years. Meanwhile, global HOPD and ASC rates also continue to rise, largely unaffected by the IPE

[5] HMA analysis 2007-2025 Medicare Physician Fee Schedule Impact Tables.

policy.[6][7] To confirm our statements, we analyzed all codes common to HOPD, ASC, and non-facility settings over a 5-year period (see Chart II).[8] Since 2021, global facility rates have never declined year-over-year, while non-facility settings declined each year through 2025. Due to policies in the 2026 PFS Proposed Rule, 2026 finally brings an increase for all three of these settings. Still, over the five-year span, cumulative rate growth is 17.5% for ASCs, 16.6% for HOPDs, and -2.8% for office-based locations.

CHART II



	2021	2022	2023	2024	2025	2026
PFS Non-Fac	0.0%	-2.5%	-4.9%	-8.6%	-10.5%	-2.8%
HOPD and PFS Fac	0.0%	1.8%	4.1%	8.4%	12.8%	16.6%
ASC and PFS Fac	0.0%	3.0%	6.0%	12.4%	15.7%	17.5%

Cuts to office-based interventionalists have become so severe that, in 2025, there are 300 procedures across service lines that are paid at rates less than just the direct costs associated with those procedures – as calculated by CMS itself (see Chart III).[9] The 2026 PFS Proposed Rule represents an important step in the right direct to correcting historical cuts to office-based interventional care, but additional actions must be taken to address this problem permanently.

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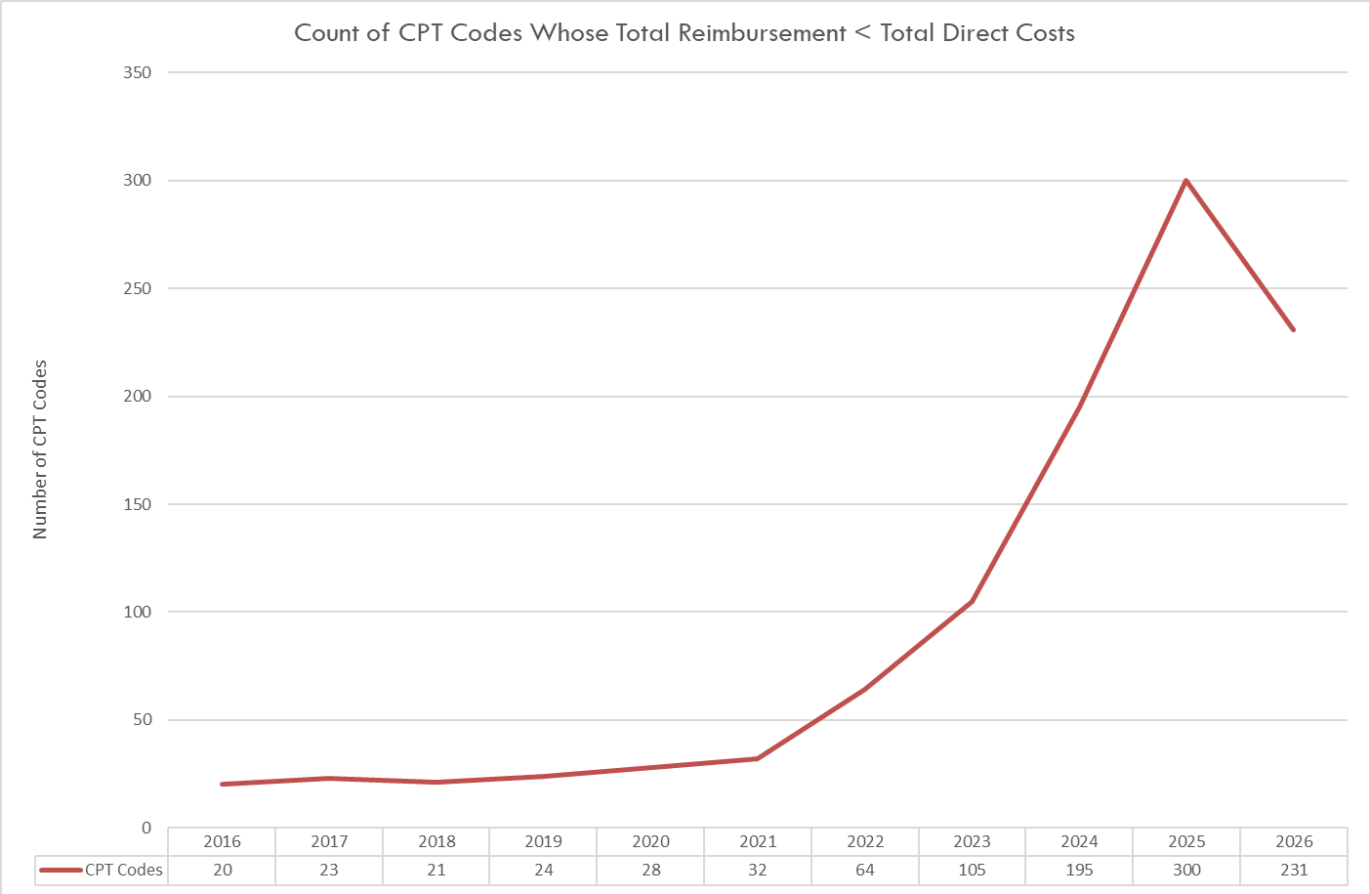
[6] In addition, physician compensation tends to include base salary, work RVUs, quality incentives, etc. rather than PFS indirect practice expense. https://sullivancotter.com/wp-content/uploads/2020/11/Infographic-2020-Physician-Compensation-and-Productivity-Survey.pdf

[7] "Global" rates means PFS nonfacility (which includes professional and technical fees) as well as global hospital outpatient fees (hospital outpatient PPS tech + PFS facility) and global ASC fees (ASC PPS tech + PFS facility).

[8] Analysis is based on data from 2021 – 2025 final rules and 2026 proposed rule for the Hospital Outpatient PPS, ASC PPS and Physician Fee Schedules.

[9] Analysis is based on data from 2016 – 2025 final rules and 2026 proposed rule for the Physician Fee Schedule.

CHART III



Physician Practice Information Survey

CMS rightly emphasizes in the rule that the AMA's Physician Practice Information Survey (PPIS) data is not a reliable benchmark for practice costs. In fact, PPIS has long blended practice expense and hourly rate (PE/HR) data between freestanding and hospital-based settings, which undermines its relevance for office-based reimbursement.[10] The PPIS survey results would have triggered significant year-over-year cuts across office-based specialty interventional services (e.g. 37225 [limb salvage]: - 10.2%, 37243 [fibroid embolization]: -12.6%, 36475 [venous ulcer]: -12.6%, 52441 [urology]: -15.2%, G6015 [radiation therapy]: -17.9, 36902 [dialysis vascular access]: -20.7%, 64555 [implant neuroelectrodes]: -26.5%).[11]

In contrast, maintaining the current MEI structures in collaboration with the IPE policy is a step toward a more equitable system. Such an approach supports community-based providers, improves access to essential preventive services (especially in rural and underserved regions), and helps reduce long-term costs for CMS. This is a meaningful and long-overdue correction and we commend CMS for taking action to preserve and strengthen community-based care delivery. For the vast majority of office-based specialties, the IPE policy will save their ability to practice independently.

[10] The Lewin Group analysis of PPIS data contained in the 2010 PFS Proposed Rule. Download available here: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/lewin_group_analysis_of_radiation_oncology.pdf

[11] Berkeley Research Group, Analysis of PPIS survey data impact on the Physician Fee Schedule, March 2025

REQUEST: The IPE policy advances patient-centered care, supports market-based solutions, and acknowledges the needs of many private practice, office-based, and independent physicians. OBFA supports the CMS proposal to update the IPE policy as a means of providing reimbursement stability that freestanding providers have desperately needed for the years.

III. USE OF OPPS DATA TO SET PFS RATES

In the 2026 PFS Proposed Rule, CMS seeks comments on whether to use Hospital Outpatient Prospective Payment System (OPPS) mean unit cost data (MUC) and/or APC relative weights to price supplies and equipment for PFS services. For years, the AMA RUC has recommended "CMS separately identify and pay for high-cost disposable supplies priced more than $500."[12] Removing high-tech supply and equipment services from the PFS also could involve new "place of service" designations for such services and more appropriate inclusion in the larger ambulatory technical (i.e. OPPS/ASC) fee schedule. We believe the inclusion of certain high-tech supply and equipment services in the larger ambulatory technical (OPPS/ASC) fee schedule would be the best way for CMS to provide an "evidentiary basis to shape optimal PE data collection and methodological adjustments over time," given previous CMS statements that, "we continue to seek the best broad based, auditable, routinely updated source of information regarding PE costs."[13] Removing high-tech supply and equipment from the PFS also would free up resources within the PFS to achieve its primary raison d'être: reimbursement for physician work.

Reimbursing under the OPPS/ASC fee schedule for certain high-cost technical inputs used in office-based interventional care would stop further closures of independent procedural practices, given that the PFS effectively no longer covers such procedures. Importantly, such a policy also would (1) protect the PFS from further dilution from unsubsidized migration of high-cost equipment and supplies from the hospital and (2) provide additional resources for the overall PFS. Moreover, there is clear precedent for such action: in the 2010 PFS, the Centers for Medicare & Medicaid Services (CMS) finalized its proposal "to remove physician-administered drugs from the definition of physicians' services" due to the "significant and disproportionate impact that the inclusion of drugs has had on the SGR system."[14]

REQUEST: Because the PFS was not built for high-cost supplies and equipment, OBFA supports the use of OPPS data to set rates for services utilizing high-cost equipment and supplies in the PFS, but recommends working with Congress to remove such services from the PFS altogether through mechanisms such as H.R. 10136 (the Promoting Fairness for Medicare Providers Act) and S. 1031 / H.R. 2120 (the ROCR Value Based Program Act).[15] Ultimately, OBFA believes that CMS should consider working with Congress to remove ALL supplies and equipment from the PFS through aforementioned legislative mechanisms.

IV. UNDERVALUATION OF CONVERSION FACTOR DUE TO G2211 ASSUMPTION

In a May 2025 letter to CMS, the AMA noted that, due to faulty assumptions relating to the adoption of the new G2211 code, that the PFS is underfunded by $1 billion. According to the

[12] https://www.ama-assn.org/system/files/oct-2020-ruc-recommendations.pdf
[13] 83 FR 59455
[14] CY 2010 PFS Proposed and Final Rules. 74 FR 33650 and 74 FR 61965
[15] https://www.cureus.com/articles/282828-the-physician-fee-schedule-was-not-built-for-high-cost-supplies-and-equipment#!/

AMA, in 2024, Medicare began paying for HCPCS code G2211, which was developed to be reported along with office visits when there is a longitudinal relationship between the physician and patient, and the physician serves as the continuing focal point for medical services that are part of ongoing care related to a patient's single, serious condition or a complex condition. Under the Medicare statute, CMS must annually adjust the Medicare CF to maintain budget neutrality, meaning that increases in payment for one service must be offset by corresponding decreases elsewhere, so that overall Medicare spending does not rise solely due to changes in relative value units. To determine the budget neutrality adjustment needed for G2211, the Biden Administration needed to develop an estimate of how frequently G2211 would be billed in 2024. The final estimate that CMS included in the CY 2024 MPFS final rule was that G2211 would be billed with 38 percent of all office/outpatient E/M visits reported in 2024. However, instead of being reported with 38 percent of all office visits, an AMA analysis of the first three quarters of 2024 Medicare claims data found that G2211 was reported with only 10.5 percent of office visits.

REQUEST: OBFA supports AMA arguments on G2211 and urges CMS to correct the utilization estimate for G2211 based on actual claims data from 2024 by making a prospective budget neutrality adjustment to the 2026 CF in the 2026 PFS final rule.

V. EFFICIENCY ADJUSTMENT

In the 2026 PFS Proposed Rule, CMS proposes applying a 2.5% decrease to the work RVUs and physician intra-service time of most services in the MPFS on the assumption that physicians have gained efficiency in providing them. This includes new services, surveyed for physician time and work within the past year. The decrease would be applied to 8,961 physician services. CMS arrives at a 2.5% efficiency adjustment by tallying the last five years' productivity adjustments in the MEI. However, physicians do not receive an MEI-based update even though other Medicare providers receive a productivity adjustment applied to their annual baseline updates (e.g., hospital market basket minus productivity). This proposal, combined with the AMA/Specialty Society RVS Update Committee's recommendations on individual CPT codes, results in the 0.55% budget neutrality adjustment to the conversion factor.

REQUEST: OBFA does not support any efficiency adjustment policies within the Physician Fee Schedule without a concurrent automatic update to the conversion factor based on MEI.

Conclusion

We look forward to continuing to work with CMS to reform the Physician Fee Schedule to ensure the viability of office-based interventional care. If you have additional questions regarding these matters and the views of the OBFA, please contact Jason McKitrick at (202) 465-8711 or by email at jmckitrick@libertypartnersgroup.com .

Sincerely,

Dr. Bob Tahara, DFOEIS, FSVS, FACS, RVT, RPVI
Health Policy Chair, Office-Based Facility Association