September 14, 2026
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-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CY 2027 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 2027 Physician Fee Schedule (CMS-1848-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
- Improving CMS Data Sources, Allocation Methodologies and Payment Rates Across Settings of Care

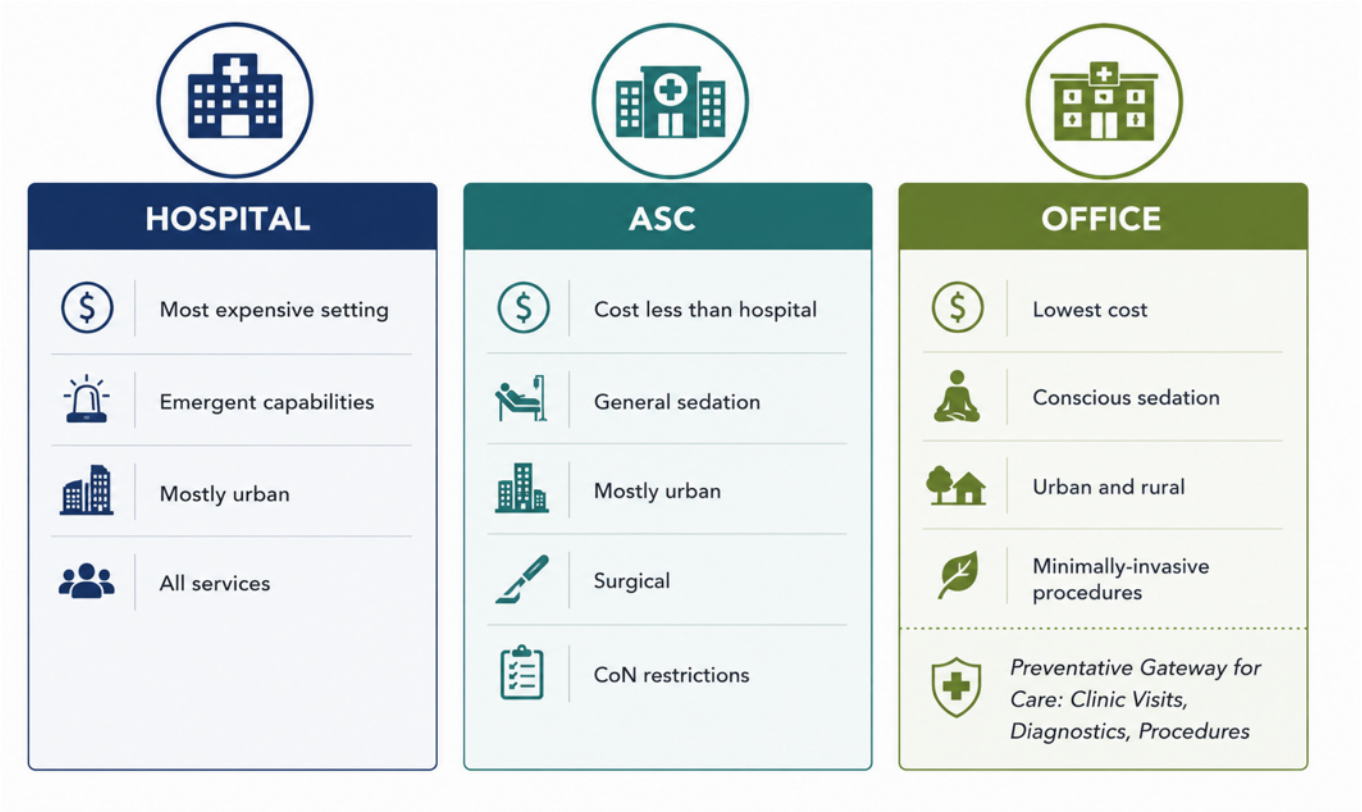
I. VALUE OF OFFICE-BASED INTERVENTIONAL CARE

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, 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. 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-

[1] Federal Register, 91 FR 43842
[2] For more information about OBFA, please see https://www.obfassociation.org/about-us

service.

FIGURE I



II. IMPROVING CMS DATA SOURCES, ALLOCATION METHODOLOGIES AND PAYMENT RATES ACROSS SETTINGS OF CARE

Notwithstanding that office-based interventional care is a critical component of the U.S. healthcare system, CMS notes in the 2027 PFS Proposed Rule the following:

- *Recent trends in physician employment and consolidation have shifted a growing share of specialists into health system-affiliated or other integrated organizational arrangements, rather than independent practice.*[5]

OBFA agrees with this perspective and would offer additional supporting data as follows:

- **American Medical Association**
  - ***Collapse of Private Practice.*** In 2024, 42.2 percent of physicians were in private practice, that is, a practice that was wholly owned by physicians. This is 18 percentage points lower than in 2012, the earliest year for which comparable data are available.[6]

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[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
[5] 91 FR 44130
[6] https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf

- **Physicians Advocacy Institute**
    - ***Hospital / Corporate Employment.*** More than four in five (82.0%) physicians were employed by hospitals or corporate entities such as private equity firms or health insurers as of January 1, 2026.[7]
    - ***Rural Access.*** Between January 1, 2019, and January 1, 2024, the number of independent physicians in rural areas fell sharply, declining 43%.[8]

CMS further notes in the Proposed Rule:

- *We are seeking comment on what are the primary variables we should consider to continue to improve our data sources, allocation methodologies, and payment rates across settings of care, to best reflect the resources involved in furnishing PFS services by professionals and suppliers operating in a complex marketplace, across settings of care. We remain interested in objective data regarding payment arrangements between hospitals, health systems, other employers and physicians, including which costs are incurred and whether the full range of costs are truly incurred by physicians and other professionals in these kinds of employment relationships. This would help us understand and improve how PE is allocated across settings of care, both in general and for specific kinds of services.*[9]

OBFA is grateful for this line of inquiry from CMS, believes it gets to the heart of the consolidation problem and, indeed, is why OBFA was founded. The remainder of this comment letter seeks to answer these questions.

An Outmoded Physician Fee Schedule Has Been a Key Driver Towards Consolidation

"[W]hen Medicare established the PFS in 1992, policymakers did not anticipate that technology would advance to the point that it would allow minimally invasive endovascular care or radiation therapy to be performed in a community-based setting."

- Rasmussen D, Yalamanchili A, Tahara B, et al. (August 27, 2024) The Physician Fee Schedule Was Not Built for High-Cost Supplies and Equipment. Cureus 16(8): e67931. doi:10.7759/cureus.67931

It's in the name: the "Physician Fee" schedule was established in 1992 to handle professional fees for physicians practicing in their chosen site of service. The concurrent advancement of technology that has allowed physicians to treat patients in a minimally invasive manner outside of the hospital and in the lowest-cost, office-based setting has been positive for patients. However, as this multi-decade trend progressed, funding for such care did not move from the Medicare Hospital Outpatient Prospective Payment System to the Physician Fee Schedule. *In other words, the Physician Fee Schedule has been subsidizing the Hospital Outpatient Prospective Payment System for years as practice expense has moved from the hospital setting to the office-based setting.*

A review of the 2027 Physician Fee Schedule Proposed Rule finds the following breakdown of equipment and supplies that currently are reimbursed by the PFS, but only for office-based services

[7] https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Health-Report-on-Physician-Employment-Trends-and-Practice-Acquisitions-2018-2026
[8] https://www.physiciansadvocacyinstitute.org/PAI-Research/Rural-Physician-Employment-and-Acquisition-Trends-2019-2024
[9] 91 FR 43861

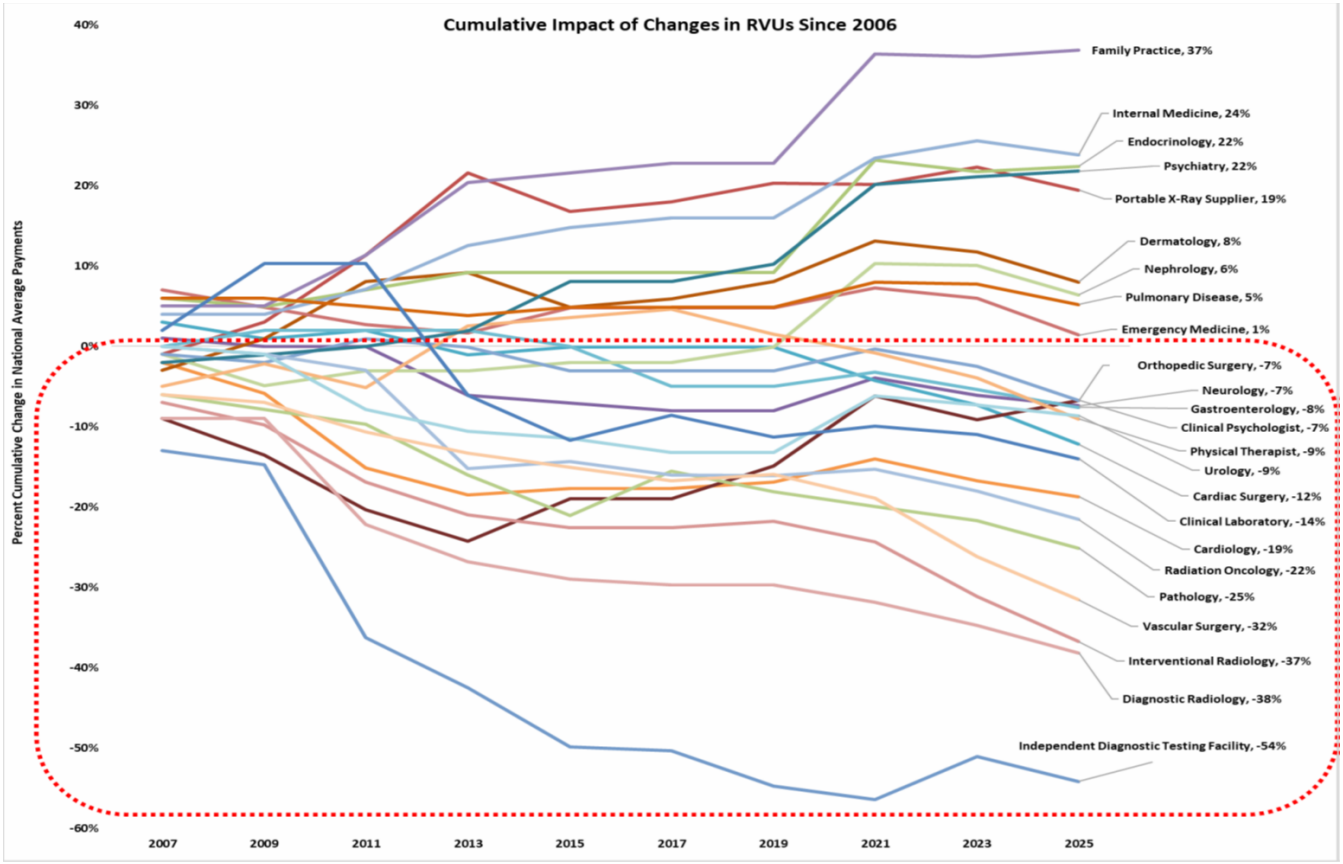
(again, practice expense in the Hospital Outpatient Department and Ambulatory Surgical Center settings is reimbursed by the HOPPS / ASC Prospective Payment System):

Equipment — 691 distinct items		**Supplies — 1,276 distinct items**	
CMS code	**Price**	**CMS code**	**Price**
ER116	$30,400,000	SD390	$14,451
ER115	$19,001,914	SD356	$12,500
ER082	$4,195,100	SA136	$8,967
ER089	$3,999,493	SD351	$7,379
ER083	$2,973,722	SD350	$7,000
EL008	$1,559,014	SD334	$6,000
EL007	$1,429,968	SA138	$5,900
ER111	$1,364,961	SA127	$5,033
EL011	$1,193,425	SD381	$4,700
ER005	$975,000	SD238	$4,523
ER034	$790,353	SA126	$4,036
ER056	$773,104	SA099	$4,000
ER097	$703,443	SD254	$3,931
EL014	$678,171	SA111	$3,721
ER072	$665,843	SD324	$3,495
EQ175	$611,943	SD380	$3,450
ER057	$601,625	SD253	$3,448
ER032	$565,000	SD255	$3,100
ER110	$527,616	SA128	$3,090

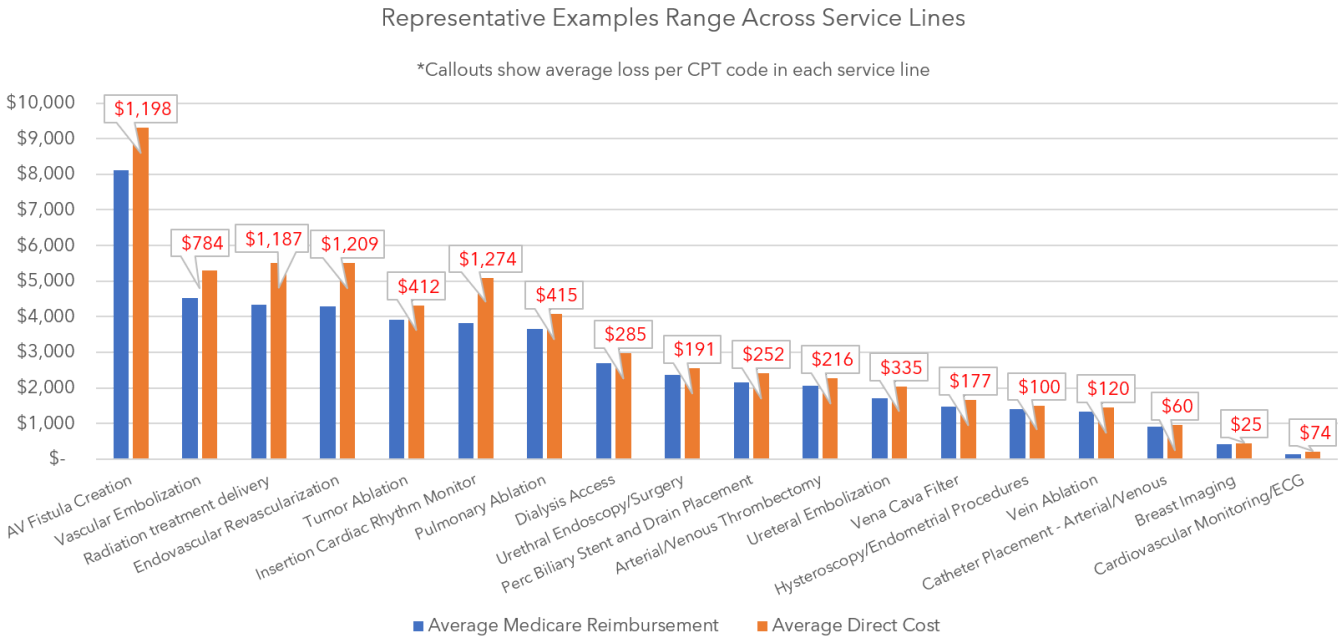
Only Congress Can Fix an Outmoded Physician Fee Schedule

Since 2006, one of policymakers' primary concerns has been to increase funding for primary care through the existing Medicare PFS regulation. While these efforts have helped primary care to some degree, they have come at the expense of physicians providing procedural care in the office, as the chart below shows.[10]

[10] Source: HMA analysis 2007-2025 Medicare Physician Fee Schedule Impact Tables. The values presented for 2021-2025 are adjusted to reflect the effects of the CAA, 2021, 2022, 2023, 2024 and the expected conversion factor reduction in 2025.

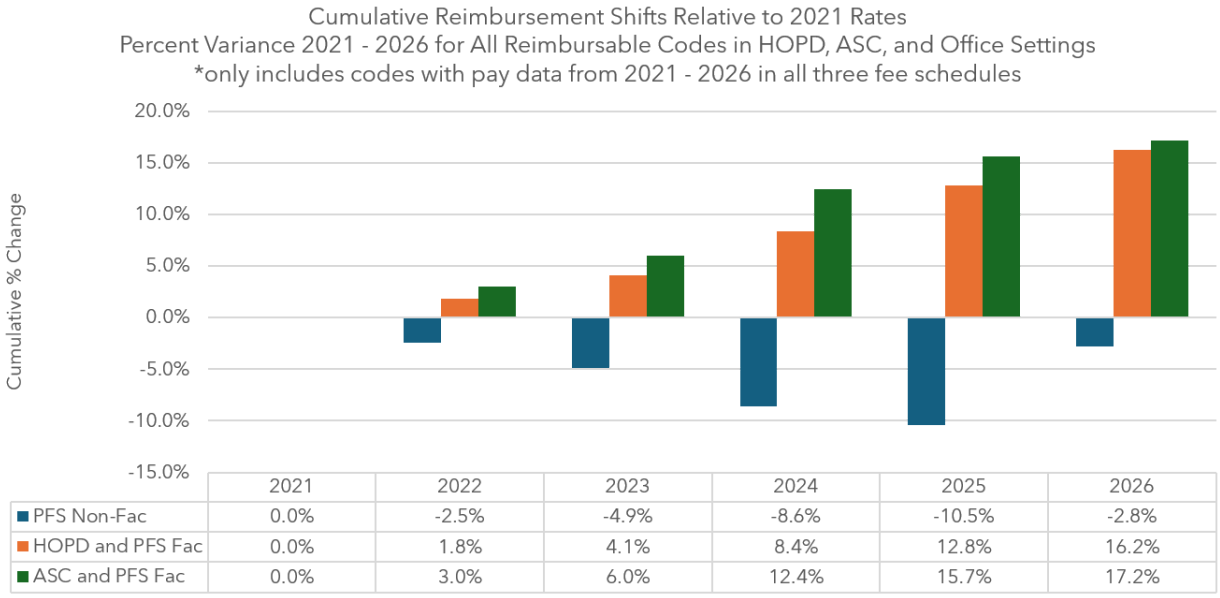


As calculated by CMS itself, cuts to office-based procedural care had become so severe that, in 2025, there were 300 procedures across service lines that were paid at rates less than the direct costs associated with those procedures, as the chart below shows.[11]



[11] Data based on 2025 Physician Fee Schedule Final Rule Total Non-Facility Reimbursement and Total Direct Costs.

The 2026 PFS Final Rule was the first meaningful improvement for office-based providers in years due to the effects of the indirect practice expense policy. Importantly, HOPD (hospital outpatient department) and ASC (ambulatory surgical center) global rates also continued to rise, largely unaffected by the IPE policy. An analysis of all codes common to HOPD, ASC, and non-facility settings over a 5-year period shows global facility rates have never declined year-over-year, while non-facility settings declined each year through 2025. The 2026 PFS Final Rule brought an increase for all three settings, despite non-facility settings remaining at a net negative over the period, as seen in the chart below.



	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%	16.2%
ASC and PFS Fac	0.0%	3.0%	6.0%	12.4%	15.7%	17.2%

With the benefit of hindsight, we can see that previous efforts to increase reimbursement to primary care have had the downside of hurting office-based procedural care due to (1) the budget neutral nature of the PFS and (2) the fact that such efforts did not address structural problems with the PFS. While more recent efforts to increase reimbursement to office-based procedural care – and office-based care overall – were an important step in the right direction, additional action must be taken to address the core problem with the PFS, which relates to *office-based practice expense*. The migration of more high-tech, high-cost procedures to the office setting will continue to add pressure to a PFS already struggling to keep pace with inflation. Over the ensuing decades, as in previous decades, the inability of the PFS to account for advanced technical infrastructure in the office will continue to dilute the value of *all* services covered under the PFS, including for proceduralists and primary care. *Only Congress can make the changes necessary to fundamentally restructure an outmoded PFS.*

PFS Structural Reform Means Thinking Beyond Inflation

While legislation has been introduced to replace recurring short-term fixes to the PFS *conversion factor* with an inflation update based on the Medicare Economic Index, such reform addresses only one dimension of a broader structural challenge within the Medicare Physician Fee Schedule (PFS). An ongoing concern is that the PFS now attempts to finance both:

- Physician professional services in all sites of service (hospital, ASC, office) and
- Advanced technical infrastructure required to deliver modern office-based procedural care.

When the resource-based Physician Fee Schedule was implemented in 1992, most technologically intensive procedures occurred in hospitals. Today, physicians can routinely provide advanced procedural care in community settings that require expensive equipment and supplies, as well as substantial capital investment, that were not contemplated when the PFS practice expense methodology was created. Indeed, office-based procedural 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, proton therapy, radiation oncology, urology, vascular surgery, and more.

As such, while an inflation-based update to the Physician Fee Schedule will help to stabilize reimbursement for physician *work*, it will not address underlying, long-standing issues surrounding the dilution of the PFS from advanced medical technologies migrating from the hospital setting to the office-based setting. To address such concerns, the PFS needs structural reform and, fortunately, a better architecture for office-based practice expense already exists.

A Better Architecture Already Exists for Office-Based Practice Expense

Medicare already maintains a mature reimbursement methodology for ambulatory practice expense: the Hospital Outpatient / Ambulatory Surgical Center Prospective Payment System. HOPPS data are collected annually, audited, nationwide in scope, transparent, and routinely updated. As such, we believe Medicare should pay for office-based practice expense outside of the PFS and consistent with how it pays for other ambulatory practice expenses by incorporating office-based technical fee reimbursement into the HOPPS / ASC fee schedule. Such an approach would:

- Rationalize practice expense across ambulatory payment systems.
- Use transparent, annually updated Medicare cost data from the HOPPS system.
- Improve predictability for independent physician practices.
- Reduce incentives for consolidation driven by payment disparities.
- Preserve patient access to lower-cost community-based care, particularly in rural areas.
- Allow the Physician Fee Schedule to focus on physician work as originally intended.
- Create a framework capable of adapting to future medical innovation.

Figures 2 describes the current approach to paying for office-based practice expense. Figure 3 describes a rationalized ambulatory practice expense payment system.

FIGURE 2: Current Approach to Paying for Ambulatory Practice Expense

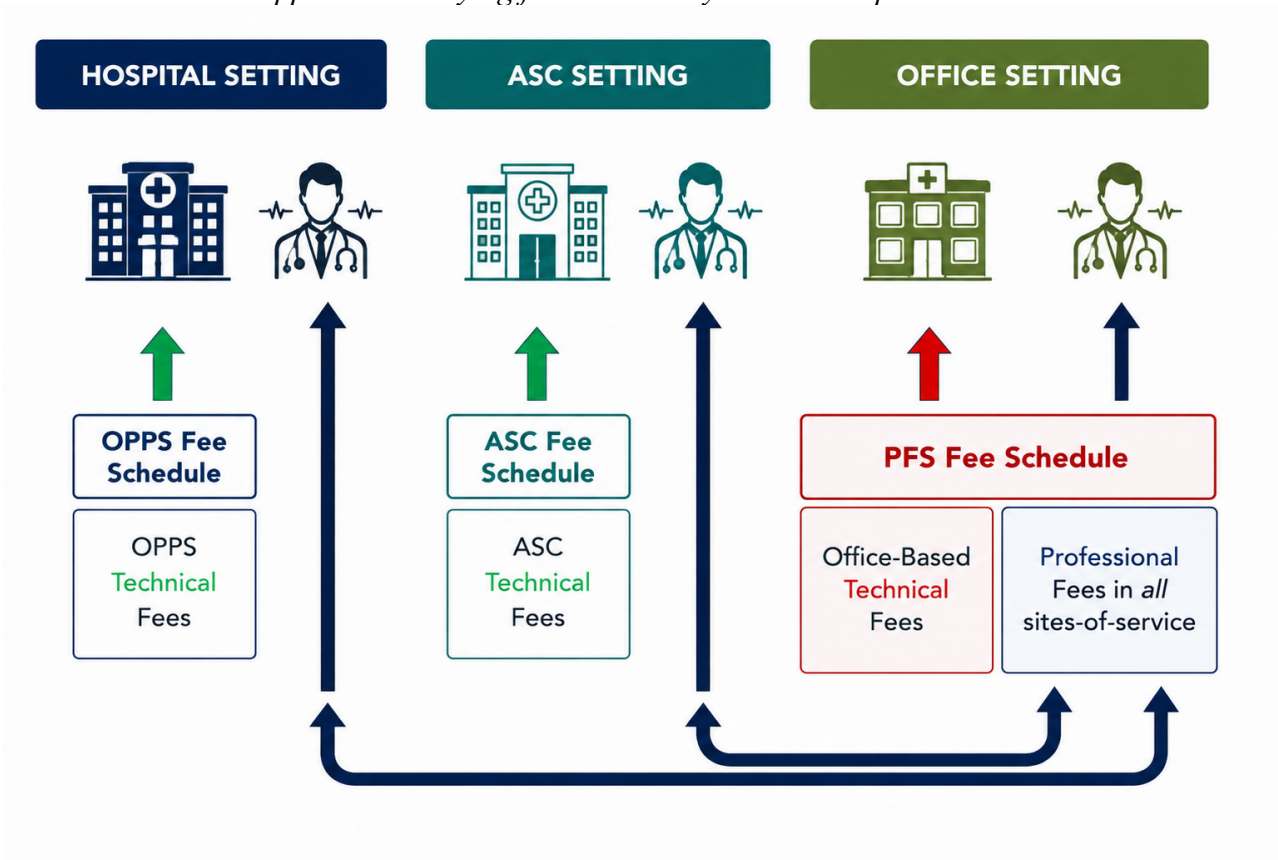
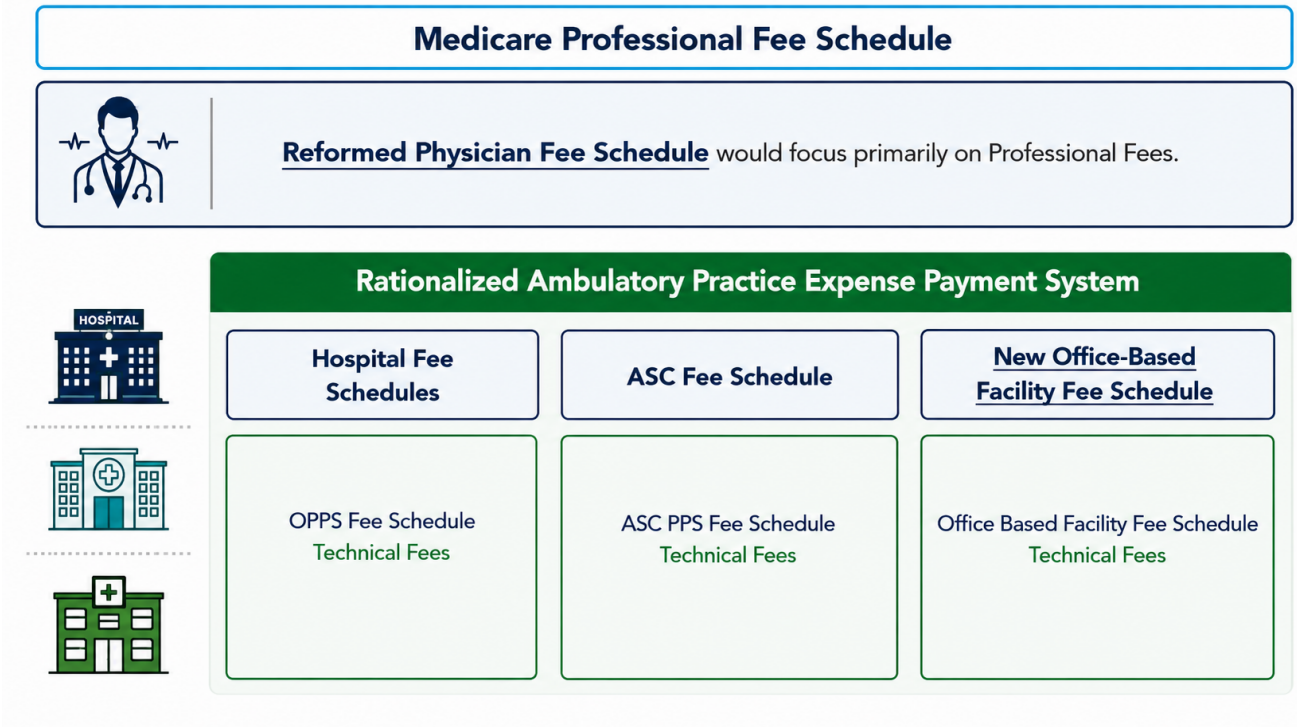


FIGURE 3: A Rationalized Ambulatory Practice Expense Payment System



While predictable, inflation-based updates of the PFS conversion factor would support physician *work* in all sites-of-service, structural reform of the PFS would address how Medicare values office-based *practice expense*. Together these approaches offer a comprehensive framework that combines payment stability for physician work with long-term modernization of the PFS to stabilize independent physicians, reverse consolidation, increase patient access, and maintain the office-based setting as the lowest cost site-of-service.

Pre-Consolidation Volumes By Setting Are a Guide for Potential Savings

According to the Physicians Advocacy Institute, the percentage of U.S. physicians practicing in physician-owned practices declined from 48% in 2018 to 18% in 2026, a 30-percentage-point decrease over 8 years. Using PAI findings as a benchmark, OBFA set the following conditions for potential savings for a new "Office-Based Facility" framework outside of the PFS:

- **Fee schedule design.** Removes office-based practice expense from the Physician Fee Schedule and, using 2026 rates, models a new office-based facility (OBF) fee schedule.
- **Rate setting.** Rates are set, with discounts as appropriate, depending on whether the service is more akin to a HOPD or an ASC and whether the service has an OPPS value.
- **Device-intensive services.** For services on the device-intensive list, device costs are carved out, consistent with the Ambulatory Surgical Center (ASC) fee schedule.
- **Growth rates.** Growth rates are set at the historical HOPPS market basket increase.
- **Volume assumptions.** No year-over-year increase in total volume is assumed.
- **Site-of-service migration.** 30% of HOPD volume is assumed to shift to the office-based setting, where appropriate.

Under these assumptions, OBFA projects 10-year savings as follows:

Modeled HOPD volume shift	Projected 10-year Medicare savings
30%	**$16.6 billion**
35%	**$31.8 billion**

REQUEST: OBFA urges CMS to work with Congress and the Bipartisan Doctors Caucus on policies which would remove office-based practice expense from the Physician Fee Schedule and create a new office-based facility (OBF) fee schedule.

Conclusion

We look forward to continuing to work with CMS to reform the Physician Fee Schedule and 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