THE AMERICAN SOCIETY OF
Breast Surgeons

September 11, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1832-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: 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 (CMS-1832-P)

Dear Administrator Oz:

On behalf of the American Society of Breast Surgeons (ASBrS), we would like to thank you for the opportunity to comment on the calendar year (CY) 2026 Medicare Physician Fee Schedule proposed rule. ASBrS is the primary leadership organization for surgeons who treat patients with breast cancer and benign breast diseases. ASBrS is committed to continually improving the practice of breast surgery by serving as an advocate for those who seek excellence in the care of breast patients. Founded in 1995, the Society now has more than 4,000 members throughout the United States and in 50 countries around the world. Active membership is open to surgeons with a special interest in breast disease.

Payment & Other Provisions of the PFS Proposed Rule

CY 2026 MPFS Conversion Factor & Reimbursements

The Centers for Medicare and Medicaid Services (CMS) has proposed a CY 2026 Medicare Physician Fee Schedule (MPFS) conversion factor of $33.4209, a 3.32% increase over CY 2024. While CMS has also proposed a $33.5875, or a 3.84% increase, for qualifying Advanced Alternative Payment Model (APM) participants, there are remarkably few APM participation opportunities for surgeons and so we expect that most of our members will provide services under the $33.2409 (+3.32%) conversion factor.

7067 Columbia Gateway Drive, Suite 290, Columbia, MD 21046 USA ● Phone: 877-992-5470 *(toll free)* ● Fax: 410-992-5472
www.breastsurgeons.org ● contact@breastsurgeons.org

While a conversion factor increase is welcomed after years of decline, this hardly represents stability in the Medicare program. Next year's proposed conversion factor comes after CMS and Congress subjected Medicare providers to a 2.83% cut in 2025, which is the fifth year in a row that CMS had subjected Medicare providers to a conversion factor cut. Further, the CY 2026 proposed positive conversion factor is only at that level because Congress created a 2.5% boost to the conversion factor that will expire on December 30, 2025, plus a budget neutrality adjustment of +0.55% that is funded by cuts that CMS proposes elsewhere in the rule, including cuts to services provided by breast surgeons. CY 2026's conversion factor continues to be affected by the significant changes in the values of the office and outpatient evaluation and management (E/M) code set implemented in CY 2021 when CMS had originally proposed a CY 2021 conversion factor that would have decreased by -10.6% from CY 2020. When CMS finalized a 10.2% reduction to the conversion factor that year, it created an unstable environment for reimbursements for services provided to Medicare patients, including for surgeons who care for patients with breast cancer.

In response,

- Congress passed several provisions in the *Consolidated Appropriations Act, 2021*, including a single year +3.75% increase to the CY 2021 conversion factor.
- When that provision expired, Congress provided another fix of +3.0%, the expiration of which combined with a new budget neutrality adjustment to exact cuts on physicians providing care to Medicare beneficiaries.
- When that provision expired, Congress, via the *Consolidation Appropriations Act, 2023* provided a 2023 boost of 2.5%.
- When the 2.5% of assistance in 2023 was set to contract to 1.25% in 2024, Congress intervened once again to provide one year of assistance 2.93%, although that provision was not effective until April 1, 2024.
- In CY 2025, CMS finalized a conversion factor cut of 2.83%.

It is clear that since 2021, CMS in conjunction with Congress have slowly been phasing in the 10.2% reduction (along with subsequent negative budget neutrality adjustments) that CMS finalized for CY 2021. Even with this year's proposed positive conversion factor, CMS is proposing a conversion factor that is 7.4% lower than it was in CY 2020. Worse, these numbers do not take into account the 2% sequestration that applies to Medicare payments since 2012 due to the *Budget Control Act of 2011* (and subsequent Congressional extensions of that sequestration).

ASBrS understands that avoiding the consequences of many of these provisions requires Congressional action. Therefore, ***ASBrS asks that CMS work with Congress to enact legislation that would avoid these cuts to payments for services provided to Medicare beneficiaries by creating an annual inflationary update for services provided under the Medicare Physician Fee Schedule***. While the Agency and Congress have instituted methodologies for nearly every other Medicare payment system that include annual update mechanisms that generate positive payment updates and take into account medical inflation, the Agency and Congress have allowed the payment system that reimburses the direct provision of care to Medicare beneficiaries by their physicians to become a fixed pie leaving physicians in an adversarial competition for resources and, worse yet, to be used as a funding mechanism by reducing Medicare physician

payments to pay for spending in other parts of the federal budget. This must stop. It is critical that CMS and Congress work together to ensure stability in the Medicare program for beneficiaries and the health care system overall.

ASBrS requests that CMS begin to consider steps that can be taken to create longer term stability in the Medicare Physician Fee Schedule. Now, several years after the passage of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), the numerous alternative payment models (APMs) that were a primary goal of the legislation have not materialized, particularly for surgeons and specialists. Without available APMs in which to participate, physicians are left to participate in the Merit-Based Incentive Payment System (MIPS), which has few relevant measures for many specialties, including ours, and has not met its goals of serving as an adequate payment update system while provide incentives to improve measurable quality. As we discuss in more detail below, CMS trying to achieve this by relying on the problematic MIPS Value Pathways (MVP) mechanism is, quite simply, insufficient.

Physicians are under the constant threat of reimbursement cuts while the cost of providing care and complexity of patients increases. As stated in the most recent Medicare Trustees Report,

> *If the health sector cannot transition to more efficient care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries will, under current law, fall over time compared to that received by those with private health insurance.*[1]

We are also concerned that allowing this to continue will exacerbate health care disparities and inequities. Population-based breast cancer mortality rates are higher among African American women and population-based incidence rates of triple-negative breast cancer are two-fold higher among African American women.[2] As shared by Susan G. Komen, breast cancer is the leading cause of cancer death in Black women and Black women are about 38% more likely to die of breast cancer than white women and have a lower 5-year relative breast cancer survival rate compared to white women.[3] Ensuring that the U.S. health care system is providing services to patients and creating better access to screening, diagnosis, and treatment for patients is all dependent on a properly financed system. We hope that CMS will consider this as it devises future policies and work with Congress where it believes it needs additional authorities.

Medicare's ability to secure medically necessary access to care for every Medicare beneficiary is paramount. The financial pressures through both statute and from actions taken by CMS will continue to make it more difficult to ensure that Medicare beneficiaries have the access to care that they deserve. This is not just the opinion of ASBrS members, but of the Medicare Trustees:

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[1] 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 3, https://www.cms.gov/oact/tr/2025, (June 18, 2025).

[2] The American Society of Breast Surgeons (ASBrS), Position Statement on Screening Mammography, https://www.breastsurgeons.org/docs/statements/Position-Statement-on-Screening-Mammography.pdf.

[3] https:/7067 Columbia Gateway Drive, Suite 290, Columbia, MD 21046cancer-statistics/ (accessed August 22, 2025).

> *Over time, unless providers could alter their use of inputs to reduce their cost per service correspondingly, Medicare's payments for health services would fall increasingly below providers' costs. Providers could not sustain continuing negative margins and would have to withdraw from serving Medicare beneficiaries or (if total facility margins remained positive) shift substantial portions of Medicare costs to their non-Medicare, non-Medicaid payers.*[4]

While ASBrS acknowledges that some of the corrective action needed to address the Trustees' concerns are in the domain of Congress, ASBrS asks that CMS consider our comments below on its CY 2026 proposals in this context.

Proposed Work RVU "Efficiency Adjustment"

To address perceived shortcomings of the AMA RUC process, CMS is proposing to reduce work RVUs for all non-time-based services to account for "efficiencies" it would expect to accrue from performing procedures over time. Specifically, for CY 2026, CMS would reduce work RVUs by the cumulative "productivity adjustments" calculated each year in the Medicare Economic Index (MEI) over the last five years, or -2.5%. CMS also proposes to apply the "efficiency adjustment" every 3 years in perpetuity without proposing a stop gap either in the formal of total devaluation from this policy over time or an exclusion from the policy because the code has been recently revalued, going so far as to apply the "Efficiency Adjustment" to procedures that were revalued in this same proposed rule.

ASBrS opposes CMS' proposal to apply an "efficiency adjustment" to work RVUs for non-time based services and urges the agency to rescind its proposal. We believe the proposal is based on a false assumption ever decreasing time/increasing "efficiency" across <u>all</u> services and would result in a severe inaccuracy in valuation of services by applying a broad reduction to <u>all</u> non-time based services without regard to the actual service being delivered, changes in the typical patient receiving the service, recent revaluations, and the harm that CMS could cause patients by assuming that all surgery gets faster in a vacuum without regard to patient quality of care or changes in the delivery of care over time. The breast surgery of today is not the same surgery that was performed even 10 to 15 years ago. While oncologic safety is the first priority, reducing deformities and defects because of the tumor removal is also a key goal of breast cancer surgery that is incorporated into the field of oncoplastic surgery. These include "hidden scar" and "moving window" incisions that are remote from the site of the tumor but placed for optimal aesthetic results. Removal of the tumor remote from the site of the incision takes more time and effort than an incision placed directly over the tumor site

If CMS finalizes this proposal, CMS will be imposing an across-the-board, unscientific, non-data driven bias to valuation of services that it says it seeks to avoid in other circumstances. As we explain in more detail below, ***ASBrS urges CMS to rescind its proposal to apply an across-the-board reduction to work RVUs for non-time based services.***

<u>CMS fails to recognize changes in breast surgery from an oncologic perspective</u>

Breast cancer surgery is one of the most rapidly evolving fields of surgery. Twenty years ago, having more than one tumor was an indication for a mastectomy. Today, we know breast

[4] 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 195, https://www.cms.gov/oact/tr/2025, (June 18, 2025).

conservation in the setting of multifocal and multicentric tumors is oncologically safe. This means lumpectomies performed today may include the removal of multiple tumors, which takes longer than the removal of a single tumor. To improve cosmesis outcomes, this is often done through a single incision and multiple lumpectomies, but because of the structure of Medicare reimbursement, this does not result in a commensurate increase in reimbursement for the increase in intensity and time of the service delivered. This example is one of many highlighting CMS' broad assumption that all procedure types are static and just become "faster" over time is incorrect.

CMS fails to acknowledge changes in breast surgery from a surgical technique perspective

A mastectomy performed without reconstruction is faster than a mastectomy with reconstruction, due to the extra skin that is preserved. Over time, rates of mastectomies performed with reconstruction have increased.[5] The longest and most difficult mastectomy for a surgeon is a nipple sparing mastectomy, where the entire skin envelope of the breast, including the nipple-areolar complex is meticulously dissected and preserved. Nipple sparing mastectomies take even more time due to the technical challenges of placing a small incision in a remote location to remove the entire breast tissue and attention to meticulous techniques to avoid ischemic compromise, skin flap violation, or nipple loss. Depending on the size of the breast and vascularity, the additional time for a nipple sparing mastectomy can be at least 2 to 3 times more than for a standard mastectomy through a large centrally located incision. A nipple-sparing mastectomy through an inframammary fold incision (NSM-IMF) is very different and can be more challenging than doing periareolar/lateral incisions. From a valuation standpoint, we remind CMS of what it already knows: there is no CPT code for the NSM, which is much more complex and takes significantly more time than a standard mastectomy.

ASBrS urges CMS to review the studies that make clear that rates of nipple sparing mastectomies continue to increase as more surgeons learn these advanced techniques[6,7] and rescind its proposal to reduce work RVUs and intraservice time for all non-time based services.

Further, breast surgery today places greater emphasis of cosmesis and decreasing toxicities from treatment, including surgical deformities. The use of oncoplastic techniques as part of a partial mastectomy are increasing.[8,9] These techniques often increase the length of a surgical procedure but provide superior patient outcomes.[10]

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[5] Jonczyk MM, Jean J, Graham R, Chatterjee A. Surgical trends in breast cancer: A rise in novel operative treatment options over a 12 year analysis. *Breast Cancer Res Treat*. 2019;173(2):267–274. doi: 10.1007/s10549-018-5018-1.

[6] Sisco M, Kyrillos AM, Lapin BR, Wang CE, Yao KA. Trends and variation in the use of nipple-sparing mastectomy for breast cancer in the united states. *Breast Cancer Res Treat*. 2016;160(1):111–120. https://doi.org/10.1007/s10549-016-3975-9. doi: 10.1007/s10549-016-3975-9.

[7] Barbieri E, Frusone F, Bottini A, et al. Evolution and time trends of nipple-sparing mastectomy: A single-center experience. *Updates in surgery*. 2020;72(3):893–899. https://pubmed.ncbi.nlm.nih.gov/32449032. doi: 10.1007/s13304-020-00796-5.

[8] Jonczyk MM, Jean J, Graham R, Chatterjee A. Surgical trends in breast cancer: A rise in novel operative treatment options over a 12 year analysis. *Breast Cancer Res Treat*. 2019;173(2):267–274. doi: 10.1007/s10549-018-5018-1.

[9] Kaufman CS. Increasing role of oncoplastic surgery for breast cancer. *Curr Oncol Rep*. 2019;21(12):111–9. doi: 10.1007/s11912-019-0860-9.

[10] Kaufman CS. Increasing role of oncoplastic surgery for breast cancer. Curr Oncol Rep. 2019;21(12):111–9. doi: 10.1007/s11912-019-0860-9.

CMS must also recognize that new technologies that do not result in new CPT codes are also introduced to improve patient satisfaction and surgical outcomes and increase time and complexity without adding reimbursement. These include technologies use of radiofrequency tumor detection devices,[11] which takes an additional 5-10 minutes to test each of the six lateralities for a total of several times per side to prevent re-excision rates; technologies to assesses margins intraoperatively using a fluorescent imaging agent that produces a signal at sites or residual tumor and a handheld optical probe, [12] and high resolution digital microscopy scanners used to assess surgical specimens intra-operatively for positive margins.[13,14] These all serve similar purposes of preventing re-excisions after surgery, while increasing intra-operative time. Our clinical and research system introduces new advancements at a fast pace, and it is the surgeons performing the procedures who must learn them. Even more illogical in CMS' proposal is the fact that, not only do these technologies increase the time associated with the procedure, contradicting CMS' assumption that these procedures have become faster, but they are all also used to assess lumpectomy margins intraoperatively to decrease the need for re-excision. This means, not only are patient outcomes better, but the Medicare program has saved money by avoiding a potential second surgery to obtain negative margins. ***CMS' decision to base payment policy on the assumption that all procedures get faster is both false and undermining quality patient care***.

As evidence of the continuous evolution of breast surgery, ASBrS has continued and increasing annual attendance in oncoplastic courses by established breast surgeons. These courses have been recently expanded to include virtual options to meet demand for them. These established surgeons are undergoing additional training and incorporating new techniques into their practice. Rather than devaluing and undermining care for breast cancer patients, CMS should employ a system that recognizes that breast surgeons today employ novel techniques in breast conservation to decrease the chance of a positive margin. These include intraoperative specimen radiography[15] and intra-operative specimen inking to allow more reliable margin assignment.[16,17] These techniques, performed by the surgeon, all increase intra-operative time and are not separately reimbursable. They are not performing the same lumpectomy year after year as CMS is suggesting in its rationale and proposed payment reduction. And these trends will continue as technologies such as robotic NSMs for risk-reducing mastectomies (RRMs) come on line, further adding to the learning and procedure times.

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[11] Rossou C, Alampritis G, Patel B. Reducing re-excision rates in breast conserving surgery with margin probe: Systematic review. *Br J Surg*. 2024;111(1):znad335. doi: 10.1093/bjs/znad335. doi: 10.1093/bjs/znad335.

[12] View pivotal INSITE study, 1. Smith, et al. NEJM Evidence 2023;2(7). DOI: 10.1056/EVIDoa2200333

[13] Imaging of lumpectomy surface with large field-of-view confocal laser scanning microscope for intraoperative margin assessment - POLARHIS study. Sandor, Mariana-Felicia et al. The Breast, Volume 66, 118 – 125.

[14] Lux MP, Schuller Z, Heimann S, et al. Re-Operation Rate for Breast Conserving Surgery Using Confocal Histolog Scanner for Intraoperative Margin Assessment-SHIELD Study. *Cancers (Basel)*. 2025;17(10):1640. Published 2025 May 12. doi:10.3390/cancers17101640.

[15]Partain N, Calvo C, Mokdad A, et al. Differences in re-excision rates for breast-conserving surgery using intraoperative 2D versus 3D tomosynthesis specimen radiograph. *Ann Surg Oncol*. 2020;27(12):4767–4776. doi: 10.1245/s10434-020-08877-w.

[16] Altman AM, Nguyen DD, Johnson B, et al. Intraoperative inking is superior to suture marking for specimen orientation in breast cancer. *Breast J*. 2020;26(4):661–667. doi: 10.1111/tbj.13508.

[17] Singh M, Singh G, Hogan KT, Atkins KA, Schroen AT. The effect of intraoperative specimen inking on lumpectomy re-excision rates. *World J Surg Oncol*. 2010;8:4–4. doi: 10.1186/1477-7819-8-4.

CMS fails to recognize changes in the patient population

Our population has more patients who undergo neoadjuvant therapies and more patients with screening-detected, non-palpable tumors. Both of these require image guided localization, which increases procedure time. This has occurred in part due to the establishment of mammographic breast cancer screening programs in combination with advancements in breast imaging technology has facilitated an increase in the detection of non-palpable breast lesions. Surgical removal of these lesions requires image-guided localization techniques. These surgeries may include using ultrasound intra-operatively to identify the lesion or using a probe to localize a previously placed tissue marker. These techniques can lengthen surgical time. Further, neoadjuvant chemotherapy is much more common to treat certain breast cancer types (triple negative and HER 2 positive) or locally advanced breast cancer that can downstage the tumor size and increase the likelihood of breast conservation. In certain instances, therapy response can obliterate any image or palpable remnant of the tumor necessitating the use of signal emitting localizing clips to identify the site of the tumor bed. This takes more time than a standard incision directly over a palpable tumor. Axillary node surgery can be similarly more challenging and take more time after neoadjuvant chemotherapy to ensure removal of the positive node with metastasis that may or may not have a clip. Targeted axillary node dissection takes more time to identify all clipped nodes and to avoid undue tissue dissection that can lead to lymphatic disruption and complications.

In addition, when performing breast conserving surgery or mastectomy, breast size can play a significant role. In the setting of breast conservation, tumor localization and tissue dissection can take longer in a larger breast. In the setting of a skin sparing or nipple sparing mastectomy, the larger the breast, the more skin flap dissection that must be performed. According to recent U.S. Centers for Disease Control and Prevention (CDC) data, the U.S. obesity rate in 2023 stood at 40.3%, with severe obesity prevalence increasing from 7.7% to 9.7% from 2013/2014 compared to 2021/2023.[18] Studies have shown operative time in breast surgery increases with increasing BMI.[19] Breast size strongly correlates with BMI.[20] Multiple studies have documented the increase in average U.S. BMI over time, with the greatest trend observed in adult women.[21] A clinical example of why this is the case is simply because the deeper axilla takes much longer to obtain a sentinel lymph node biopsy (SLNB) or axillary lymph node dissection (ALND).

Further, as breast cancer systemic therapy improves and patients are cured of their first cancer and are living longer, local recurrence or a new breast primary is not uncommon. Surgery of a previously treated breast is technically more challenging and requires meticulous technique to reduce complications. Likewise, surgery in a previously radiated and operated axilla also requires more time to dissect through scar tissue to avoid injury to nerves and critical blood vessels.

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[18] https://www.cdc.gov/nchs/products/databriefs/db508.htm (accessed August 25, 2025).

[19] Tata N, Byskosh A, Helenowski I, Dunderdale J, Jovanovic B, Kulkarni S. The effect of obesity on operating room utilization in breast surgery. *J Surg Res*. 2021;260:229–236. doi: 10.1016/j.jss.2020.10.012.

[20] Estler A, Zanderigo E, Wessling D, et al. Quantification of breast volume according to age and BMI: A three-dimensional MRI analysis of 400 women. *Aesthetic Plast Surg*. 2022;47(5):1713–1724. https://pubmed.ncbi.nlm.nih.gov/36418548. doi: 10.1007/s00266-022-03167-0.

[21] Hales CM, Fryar CD, Carroll MD, Freedman DS, Ogden CL. Trends in obesity and severe obesity prevalence in US youth and adults by sex and age, 2007-2008 to 2015-2016. *JAMA*. 2018;319(16):1723–1725. doi: 10.1001/jama.2018.3060.

It is also well-documented that with an aging population, the comorbidities for those patients are higher, and therefore, they are sicker and may extend intraoperative time. In some of these instances, the cases extend for times well-beyond what is valued in the code. If CMS was interested in paying accurately for these cases and ensuring that the most complicated cases were properly resourced, then CMS would better recognize cases appropriately submitted with Modifier 22 (*Increased procedural service)*. Yet, the CMS Medicare Administrative Contractors (MACs) continuously fail to recognize the increased reimbursement that Modifier 22 should trigger and, worse yet, deny claims with Modifier 22 at higher rates.[22]

CMS fails to consider any of these factors in its proposal and should rescind the "efficiency adjustment" proposal to cut all non-time-based procedures.

CMS fails to recognize the evolution of training in breast surgery

As breast surgical techniques continue to evolve and become more complex, training future surgeons takes more time, especially through the more advanced techniques that utilize limited view incisions and more difficult for the learner. In this setting of early learners, there is no "efficiency adjustment" that will ever be realized.

CMS fails to recognize overall improvements in breast surgery patient care and outcomes

While theoretically, efficiencies in technique potentially occur with experience and time on delivery of a service, these assumptions presume that breast surgery is static in disease stage, surgical technique, and patient characteristics. The only rationale CMS could have for applying an 'efficiency adjustment" would be if this were the case, and there is no such static environment in most medical services. This is particularly true for breast cancer surgery which is constantly becoming more complex, where patients have more comorbidities, and we are operating on more patients who now present with a second breast cancer. To assign reimbursement based on "cutting time" rather than encouraging quality outcomes and improved patient satisfaction will lead to negative, unintended consequences.

Overall, ***ASBrS is concerned that CMS is departing from valuing services based on the concept that some cases would be easier and some more difficult and therefore the work RVU should represent the average time. However, in the examples above, particularly in the case of exponential growth in the volume of NSMs, there has not been any upward adjustment of time and effort in the valuation of breast surgery. Not only does CMS fail to recognize that increased work and complexity, it seems that CMS is seeking to undermine breast cancer treatment by shifting its policy to attempt to pay for the "fastest" surgery, particularly as it seeks to finalize a policy that would execute an "efficiency adjustment" in perpetuity without any regard for science, data, patient outcomes, or patient-centered care. ASBrS opposes CMS' "efficiency adjustment" on these grounds and urges CMS to rescind the proposal to apply an "efficiency adjustment" and that it would do so it perpetuity.***

[22] Childers CP, Manisundaram NV, Hu CY, et al., Modifier 22 Use in Fee-for-Service Medicare *JAMA Surg* (2024) 2024;159;(5):563-569. doi:10.1001/jamasurg.2024.0048.

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

Citing concerns about the evolution of practice structures and employment trends by the health systems where facility-based services are delivered, CMS is proposing to shift PE RVUs from services that are delivered in the hospital or ASC to services that are delivered in the non-facility or office setting. Specifically, CMS proposes cutting PE RVUs that are derivative of work RVUs by 50%.

While CMS cites concerns that Medicare is overpaying for indirect/overhead expenses when a physician is employed by the hospital where they perform the service, the methodology for the PE realignment would cut payment for essentially all procedures performed in the hospital or ASC setting (regardless of employment status) and increase payments for essentially any service that is provided in the office setting (regardless of employment status) by using the "facility" Place-of-Service as a proxy for employment and/or a lack of office-based practice behind the physician delivering services in the facility setting.

ASBrS opposes CMS' proposal to reduce facility indirect PE RVUs because the policy is overbroad, fails to achieve CMS' stated goals, lacks a quantitative rationale for the reduction amount, and undermines that accuracy and integrity of the Medicare Physician Fee Schedule.

CMS makes a false proxy between service delivery in the facility setting and hospital employment status and/or lack of office-based practice

ASBrS recognizes that the practice of medicine is constantly changing and delivery models evolve over time. However, to execute a cut in reimbursement to all services delivered in the facility setting because CMS believes the percentage of hospital-employed physicians has increased or because physicians who furnish services in the facility setting offer no office-based services is an irrational connection. If CMS were to finalize this policy as proposed, CMS will be severely cutting practice expense reimbursements to breast surgeons in independent practice, who continue to struggle to maintain those practices as Medicare continues to make cuts to physician payments. Likewise, because of CMS' practice expense budget neutrality policy, CMS will be significantly increasing practice expense reimbursements to physicians who are employed by hospitals and health systems but that offer office-based services. The proposed policy is quite simply irrational in its application.

ASBrS also urges CMS to review its assumptions and proposals in light of states that maintain laws and/or regulations against the Corporate Practice of Medicine. In California, Colorado, and North Dakota, to name only a few, where direct physician employment by hospitals is constrained by Corporate Practice of Medicine restrictions, CMS is still proposing to cut reimbursements to all services delivered in the facility setting even though it is patently obvious that CMS' facility/employment proxy cannot be true in most situations. ***Because of this incongruity, ASBrS urges CMS to withdraw its proposal to reduce indirect facility PE work-derived RVUs by 50%.***

CMS makes general financial assumptions about hospital-employed physicians that are not generally applicable

Inherent in CMS' rationale for its proposal to reduce indirect facility PE RVUs is an assumption that the incremental indirect costs that a hospital or health system incurs when it employs a

physician are fundamentally less than the indirect costs of an independent practice but provides no basis for this argument. At its core, this discussion is one of the relative indirect costs that are associated with the delivery of care by physicians. Indirect costs like coding, billing, scheduling exist for each and every professional service delivered by a physician. Even if a hospital employs a physician, the billing entity for those physicians continue to carry all of those incremental indirect costs. The hospital still incurs administrative costs on a per case basis for billing and coding. CMS also fails to recognize that the administrative overhead for insurance authorization on a per case basis continues to increase. This is no longer just applicable to commercial insurance. Here, CMS is proposing to reduce the practice expense for these functions that are incremental to each professional service that is delivered regardless of the billing entity, while at the same time proposing additional burdensome prior authorization of its own under the WISeR Model[23] as well as the burden and cost of complying with CMS' MIPS reporting requirements. We are concerned that CMS fails to appreciate the true nature of indirect costs that are associated with billing and quality reporting requirements because none of these costs just evaporates when a physician becomes employed by a facility.

In addition, CMS need look no further than our members who have dedicated their careers to treating patients with breast cancer to know that CMS' assumption that if a service is delivered in the facility setting, then there is no office-based practice behind those procedures is objectively false. Breast surgeons provide significant time and care to patients in our offices. To cut payments for breast surgery under the assumption that there is no office-based care associated with the procedures is unacceptable for our members.

For these reasons, ***ASBrS urges CMS to take the following actions:***

- ***ASBrS urges CMS to withdraw its proposal to reduce work-derived facility PE RVUs by 50%***
- ***ASBrS urges CMS to collect reliable, researched data to identify whether there are actual differential indirect costs incurred by the delivery of a service by a physician who is hospital-employed and those incurred by the delivery of a service by physician who is in independent practice and quantify them based on reliable, verifiable data***
- If CMS pursues a new policy in the future or adopts any version of what it proposed for CY 2026, ***ASBrS urges that CMS apply the policy more directly to the providers it believes have lower indirect costs by either:***
    - ***Developing a data-driven PE adjustment factor that would be applied similarly to GPCI adjustments (rather than distorting the entire PE allocation of the PFS as it does under the current proposal) for employed physicians (which could be triggered by appending an "employed" modifier to a code on a claim); or***
    - ***The development of a new PE column in the fee schedule that would be data-driven and calibrated to reflect the PE of employed physicians***

Improving the Accuracy of Global Surgery Valuation

Prior to 2025, surgeons were to append Modifier 54 to a code with a global period if there was a formal transfer-of-care and another physician was going to take over the care of the patient after a surgery was performed. Starting in 2025, CMS expanded the use of Modifier 54 from formal

[23] https://www.cms.gov/priorities/innovation/innovation-models/wiser.

transfers-of-care to more broadly apply any time the surgeon does not "expect" or "intend" to deliver post-operative care. Both prior to and in 2025, when you append Modifier 54 to a CPT with a global period, that modifier executes a reduction to the payment of the service. That reduction is based on the percentage that each individual code has assigned to it in the Medicare Physician Fee Schedule file, which is intended to reflect the percentage of the global period value that is proportional to the value of the surgery.

Expressing concern about the procedure portions in the file, CMS seeks input on several different approaches to recalculating the procedure portions of 90-day global periods:

- Approach A: Status quo
- Approach B: Define procedure shares as proportion of work in each global period
- Approach C: Reset procedure shares based on data collected under CMS' post-op visit reporting requirement of CPT 99024
- Approach D: Define procedure shares as a proportion of time in each global period.

ASBrS encourages CMS to refrain from use of any of these approaches as we believe each is problematic for determining the accuracy of payments when Modifier 54 is appended to a claim.

First, in suggesting (and preferencing) Approach C (i.e., resetting the procedure portion based on collection of CPT 99024 "data"), CMS ignores the recent U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) Report,[24] which found after medical record reviews that CMS' CPT 99024 data collection effort severely undercounted the actual number of post-operative visits performed. The HHS OIG states,

> *For 45 of 105 sampled global surgeries, a total of 98 postoperative visits were not accurately reported to CMS. Based on our sample results, we estimated that for 47,421 of the 110,650 global surgeries in our sampling frame, there was a difference of 103,273 postoperative visits between the number of visits reported and the number of visits provided. This occurred because practitioners were unfamiliar with CMS's data collection requirements, or their billing systems were not designed to always submit CPT code 99024 on claims to CMS.* (citations omitted).

CMS replied to the HHS OIG regarding its findings and recommendation on March 19, 2025,[25] yet still suggested that use of the CPT 99024 data was its preferred method for resetting the procedure share percentages in the globals. ***ASBrS opposes the use of any CPT 99024 "data" for any ratesetting efforts given the findings of the HHS OIG.***

Regarding the other options, ***ASBrS also opposes the use of Approach B (work proportion) and Approach D (time proportion) because CMS has distorted the integrity of the relativity of the MPFS by (a) failing to provide commensurate increases to the global surgical packages based on the 2021 re-valuation of the office and outpatient E/M codes sets; and (b) by now introducing an unscientific, unsupportable "efficiency adjustment" to work RVUs.*** ASBrS and

[24] https://oig.hhs.gov/documents/audit/10428/A-05-20-00021.pdf.

[25] *See*, Appendix G: CMS Comments at https://oig.hhs.gov/documents/audit/10428/A-05-20-00021.pdf.

our members have always supported the accuracy of valuation of services in the PFS and will continue to do so. ***But CMS' own actions to apply across-the-board devaluations to global surgical packages in CY 2021 and now with the "efficiency adjustment" proposals render CMS' time and work file calculations to be an inadequate data source for determining procedure share portions for purposes off altering application of Modifier 54***.

Medicare Payment for Approved Telehealth Services

ASBrS appreciates the CMS efforts to ensure that patients are able to access health care from remote locations by furnishing services via interactive telecommunications systems. We understand that maintaining access to these services via telehealth for many patients outside of certain geographic areas and outside of "originating sites" is defined by statute and for the recent flexibilities to be extended beyond September 30, 2025, Congress must act. ***ASBrS urges CMS to work with Congress to ensure that the telehealth waivers are extended permanently to ensure patient access to care, especially in situations where patients are living in rural areas or medically underserved areas***.

Quality Payment Program (QPP)

Merit-Based Incentive Payment System (MIPS) Quality Measures

The ASBrS concurs with CMS's proposal to remove quality measure *#264: Sentinel Lymph Node Biopsy for Invasive Breast Cancer* from MIPS beginning with the CY 2026 performance year. ASBrS is the steward of this process measure, which is based on 2010 guidelines and assesses the percentage of patients with a diagnosis of primary invasive breast cancer who undergo a sentinel lymph node procedure. ASBrS invested early in the development of breast surgery-specific quality measures for use in federal quality reporting programs. Measure #264, in particular, has been part of MIPS since the start of the program in 2017, and was carried over from its predecessor program, the Physician Quality Reporting System (PQRS). However, over time, use of this measure has declined to the point that it failed to accrue a benchmark starting with the 2021 performance year. As a result, surgeons who currently elect to report the measure receive no credit. These trends are largely the result of dramatic changes in clinical practice due to evolving indications for sentinel lymph node biopsy in invasive breast cancer. Several recently published large international studies have concluded that sentinel lymph node biopsy is actually NOT recommended in a significant portion of patients with clinical T1 invasive breast cancer, which has led to a change in practice Since more patients are being recommended to avoid sentinel lymph node surgery, fewer patients are needing surgical axillary staging, and therefore the number of patients excluded from this measure continues to increase. ***In light of these trends, the ASBrS made the decision to retire this measure, effective December 31, 2025, and supports CMS's proposal to remove this measure from MIPS and from the Surgical Care MVP, starting with the CY 2026 MIPS performance year.***

Despite the retirement of our quality measure from the Surgical Care MVP, ***the ASBrS supports CMS's proposal to maintain the Lumpectomy, Partial Mastectomy, Simple Mastectomy episode-based cost measure in the Surgical Care MVP***. ASBrS clinical experts played a prominent role in the development of this cost measure, which captures episodes specific to the care being provided by breast surgeons and could encourage more breast surgeons to start testing the use of this MVP.

MIPS Performance Threshold

CMS proposes to maintain the MIPS performance threshold, which is the minimum number of points needed to avoid a penalty, at 75 points for the CY 2026 performance period/CY 2028 payment year through the CY 2028 performance year/CY 2030 payment year. ***ASBrS supports CMS's decision to maintain the current performance threshold for three additional years. We also appreciate CMS recognizing the importance of keeping program rules consistent year after year as CMS embarks on several large programmatic changes, including transitioning to MVPs.***

Cost Category Policies

Proposal to Adopt a Two-Year Informational-Only Feedback Period for New MIPS Cost Measures

Beginning with the 2026 performance period, CMS proposes to provide a 2-year informational-only feedback period for new cost measures. ***ASBrS strongly supports this proposal, and agrees that an informational-only feedback period would allow MIPS eligible clinicians time to gain familiarity with the cost measures and identify any issues specific to a measure that might require a re-evaluation, prior to scores affecting MIPS final payment adjustments. We also request that CMS consider extending this policy to existing cost measures that undergo re-evaluation and substantive changes. This would give clinicians time to understand the impact of the revisions and CMS time to ensure the revised measure is working as intended.*** We remind CMS that many physicians have faced challenges both accessing and making sense of cost measure performance feedback reports distributed to date. ***If this proposal is finalized, we urge CMS to work with impacted stakeholders to ensure that feedback reports are easier to access and understand than reports distributed to date.***

ASBrS has ongoing concerns with the cost measures developed to date and hope that in addition to this proposal, CMS will continue to work with Acumen to address these issues. For example, cost measures continue to rely exclusively on administrative claims data, which do not provide a complete picture of patient care and limits the accuracy of critical measure components, such as risk stratification, subgrouping, and defining appropriate inclusion and exclusion criteria. Claims data are also easily impacted by coding practices. For example, practices that have the resources to code for every comorbidity will benefit from risk-adjustments and likely perform better on a cost measure compared to a practice with limited resources. We also remind CMS of the ongoing need to better account for quality when measuring cost. Currently, all of the cost measures developed for MIPS evaluate cost in isolation, without assessing the impact that cost reduction may have on patient outcomes.

Proposed Changes to the Total Per Capita Cost (TPCC) Measures

Beginning with the 2026 performance period, CMS proposes to revise the *Total Per Capita Cost* (TPCC) measure so that 1) clinicians are only attributed costs for beneficiaries that have had at least two qualifying services from their clinician group (currently, the second service could be from outside the group), and where both services were provided by a clinician that is not excluded from measure attribution due to the specialty exclusion; and 2) so that advanced care practitioners (APPs) are excluded from attribution in specific specialty settings (i.e., in situations where *all* physicians in a group are excluded based on the specialty exclusion criteria).

The ASBrS appreciates CMS proposing to take action to address long-standing issues with this measure. Excluded specialties, including breast surgeons (via the general surgery exclusion), are often inappropriately pulled into this measure and receive relatively low scores on the measure, which negatively impacts their final MIPS score. ***At the same time, ASBrS views the proposed changes as an insufficient solution since they still allow for attribution based on excluded specialties. It is inappropriate, and against the intent of the measure, to hold clinicians who are not providing primary care accountable for this measure. We request that CMS better identify clinicians who should be excluded from this measure based on their claims data and voluntary reporting of patient-relationship codes. Until these issues are addressed and the TPCC measure accounts only for costs within the direct control of the physician, we urge CMS to remove this technically flawed measure from the program.***

If CMS opts to maintain this measure and adopt its proposed revisions, at the very least, it should:

- ***Remove the TPCC measure from MVPs where a more specific episode-based cost measure already exists; and***
- ***Apply the proposed updates beginning with the <u>CY 2025</u> performance period in order to minimize the widespread negative impact of the current flawed measure specifications on specialty practices.***

* * *

ASBrS appreciates the opportunity to provide comments on the CY 2026 MPFS proposed rule. If you have questions or if ASBrS can ever be of assistance, particularly on any breast cancer and patient education efforts, please do not hesitate to reach out to Sharon Grutman, Director of Advocacy, Communications, and Quality Initiatives, at sgrutman@breastsurgeons.org.

Sincerely,

Michael Berry, MD
President