AMERICAN COLLEGE OF SURGEONS

September 12, 2025

Mehmet Oz, MD, MBA
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: 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 over 90,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2026 Medicare Physician Fee Schedule (MPFS) proposed rule published in the *Federal Register* on July 16, 2025.

The ACS is a scientific and educational association of surgeons founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. Since a large portion of our members' performance is measured and paid for under the provisions of this rule, the ACS has a vested interest in the MPFS, Quality Payment Program (QPP), and Center for Medicare & Medicaid Innovation (CMMI, or the Innovation Center) initiatives. With our more than 100-year history in developing policy recommendations to optimize the delivery of surgical services, lower costs, improve program integrity, and make the U.S. healthcare system more effective and accessible, we believe that we can offer insight to the Agency's proposed changes to the MPFS, QPP, and Innovation Center initiatives. Our comments below are presented in the order in which they appear in the rule.

PROVISIONS OF THE PROPOSED RULE FOR THE MPFS

Development of Strategies for Updates to Practice Expense Data Collection and Methodology

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

Under the current resource-based relative value scale (RBRVS) framework, indirect practice expense (PE) relative value units (RVUs) are designed to reflect administrative

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overhead such as rent, administrative staff, and office supplies, as opposed to costs directly attributable to a single service such as clinical labor, supplies, and equipment.

CMS expresses concern that facility-based indirect PE payments may result in "double counting" when hospitals employ physicians, as some of these overhead costs may already be reflected in separate facility payments under the Outpatient Prospective Payment System (OPPS). Therefore, for each service valued in the facility setting under the MPFS, the Agency proposes to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026. CMS justifies this proposed cut by contending that the equal allocation of indirect PE across facility and non-facility settings no longer reflects modern practice realities, namely the growing number of hospital-employed physicians whose overhead costs may be carried by the facility depending on their employment arrangements.

While the ACS shares CMS' commitment to ensuring that physician reimbursement appropriately reflects the resources required to furnish services, we disagree that the Agency's efforts to identify and eliminate indirect PE payments it believes it is paying for elsewhere should occur within the fee schedule—we believe that if there are economies of scale in indirect PE that result from employment of physicians that the ***hospitals***, not physicians, are the entities accruing that benefit through both OPPS facility payments and the MPFS claims they submit on behalf of their physician employees. As noted by CMS in this proposed rule, the percentage of physicians working in hospital-owned practices has increased from 23.4 percent in 2012 to 34.5 percent in 2024. In addition, 12.2 percent of physicians were employed directly by a hospital (or contracted directly with a hospital) in 2024, up from 5.6 percent in 2012. **Given that employed physicians never receive the facility fee, they are not the beneficiary of this perceived imbalance. The Agency cannot correct such an imbalance through the MPFS since, per information cited by CMS, the majority of physicians in the U.S. are not employed by hospitals. We strongly urge the Agency to instead provide actual data on how the indirect cost differentials for physician services change when a physician is employed by a facility under the OPPS to properly target any potential overpayments made to hospitals for indirect practice expenses.** Furthermore, CMS imposes this policy on ***all*** physician services furnished in the facility setting, regardless of the physician's employment status or practice structure, thus introducing a misguided overhaul of an extremely large and fundamental portion of the MPFS. We are deeply concerned that the Agency's proposal is not data-driven, is overly broad, and would impose disproportionate harm on physicians who provide services in a facility setting but are not hospital-employed. **Specifically, we believe that CMS' proposal:**

- **Lacks empirical support.** CMS suggests that current policy may result in "double payment" for indirect expenses. However, the Agency has failed to provide robust data quantifying the magnitude of any such overpayments, and its methodology—arbitrarily halving the portion of indirect facility PE RVUs tied to work RVUs—is applied universally without any evidence delineating how much of that overhead is truly redundant or varies by the arrangements under which physicians are employed. Even when a physician is clearly and fully employed under a definition that all parties would accept, the supporting activities required for their services (e.g., scheduling, coding, billing, other indirect costs) remain real expenses tied to that physician and do not evaporate because their employment entity is a hospital. Conversely, a hospital that does not employ physicians—and therefore does not provide coding and billing services for professional claims—naturally incurs lower costs. For example, the payment made under OPPS for outpatient surgical procedures is specifically designed to capture the facility's costs associated with furnishing the service, including operating room expenses, staff, equipment, and disposable supplies. OPPS payment, however, is *not* intended to account for the practice expenses of the surgeon, such as the surgeon's office space used to dictate

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the operative note, the time and services of medical assistants, and the administrative costs of coding and billing for the surgeon's professional fees, therefore invalidating the Agency's assumption that physicians are receiving duplicative indirect PE payments by Medicare and their employers. CMS makes no attempt to acknowledge these distinctions, investigate whether such cost differentials exist, or quantify the extent of any differentials for a given facility service when furnished by hospital-employed physicians versus non-hospital-employed physicians.

CMS itself acknowledges significant limitations in existing cost surveys (i.e., the Physician Practice Information Survey and Clinician Practice Information Survey) due to low response rates, sampling variation, and representativeness issues, leading the Agency to defer use of these data for CY 2026. In its June 2025 report to Congress, the Medicare Payment Advisory Commission (MedPAC) emphasized the need for more timely, objective data to reflect current practice environments and cautioned against relying on outdated allocation shares, which underpin PE RVUs.[1] **To justify a policy that would have significant consequences for physician payment and long-term practice sustainability, CMS must first collect and present credible data that sufficiently demonstrate:**

- **The degree to which indirect PE payments are duplicated, if at all, irrespective of employment arrangements due to the different nature of facility expenses under the OPPS (e.g., outpatient surgery nursing staff, operating room supplies) compared to indirect PE under the MPFS (e.g., clinic schedulers, medical assistants, rent);**
- **The actual cost differential between employed and independent physicians under the RBRVS;**
- **Differences in overhead costs across various employment arrangements (e.g., full employment, contracting, practice ownership);**
- **The degree to which indirect PE payments are duplicated, if at all, between different employment arrangements; and**
- **Whether indirect PE differentials are warranted and at what level.**

Without systematically addressing these issues, CMS risks advancing a policy that is fundamentally flawed, inequitable in impact, and damaging to both the viability of independent physician practices and patient access to care.

- **Applies too broadly in scope.** While the Agency's intent may be to reduce duplicative overhead payments for hospital-employed physicians, its approach applies the reduction to *all* facility-based services, regardless of practice structure, and therefore does not achieve CMS' stated goal of targeting only those whose overhead is covered by hospitals. As currently proposed, the impact of the Agency's indirect PE adjustment—estimated at -7 percent in facility settings and +4 percent in non-facility settings—would markedly distort the RBRVS. **If the Agency seeks to address differential overhead costs for hospital-employed physicians, its method to do so must be precisely tailored to capture only those specific arrangements rather than penalizing the entire physician community**. However, we wish to highlight that even a narrowly targeted reduction could still significantly shift indirect PE spending and affect payment relativity across services within the MPFS.[1]

- **Creates perverse payment incentives.** CMS' proposal could result in increased payment for certain physicians billing office visits in the non-facility setting despite being employed by a hospital, which would directly contradict the Agency's objective of avoiding duplicative payments—this scenario

[1]Medicare Payment Advisory Commission. *Report to Congress: Medicare and the Health Delivery System*. June 2025. Accessed August 28, 2025. https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_MedPAC_Report_To_Congress_SEC.pdf.

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further emphasizes why it is not accurate to use the facility setting as a proxy for physicians' employment status. Additionally, it would create a perverse financial incentive for hospitals to consolidate by acquiring independent physician practices and shifting more services into the non-facility setting where higher payments may apply. Such a shift would accelerate the ongoing trend of market consolidation, reduce competition, and further inflate costs for patients.

- **Inappropriately shifts cost savings to non-facility services.** Regardless of the approach taken, any savings CMS achieves by addressing perceived duplicate indirect PE payments should not be reallocated to non-facility PE RVUs. **Instead, such savings should be redistributed via a budget neutrality adjustment to the MPFS conversion factor (CF) to maintain relativity across all specialties and settings, rather than inflating payments selectively for non-facility services.** As discussed above, the Agency has not provided a data-based justification for the proposed percent reduction in facility indirect PE, nor evidence to support the significant increase in PE RVUs that would be shifted to non-facility services under budget neutrality. Consequently, while this overly broad policy would substantially reduce payments for many independent practice physicians, CMS' budget neutral approach would markedly increase payments for many employed, office-based physicians.

Alternative Approaches

If CMS must move forward with a mechanism to address facility-based PE RVUs under the MPFS in light of the growing number of hospital-employed physicians, the ACS suggests two potential alternative approaches that would better enable the Agency to tackle its stated concerns regarding the indirect PE differentials.

- **Option A: Employed physician modifier and PE RVU adjustment factor.** CMS could develop a new modifier, such as "FE" for "facility-employed" physician, that would be appended to claims for services furnished by physicians who are employed by the facility in which they provided the services billed. When modifier "FE" is reported, it would trigger an adjustment factor—similar to a Geographic Practice Cost Index (GPCI)—that would be applied to the Medicare payment calculation formula, therefore leaving RVUs intact. Under this approach, the revised payment formula would be:

MPFS Facility Payment =
([RVUw * GPCIw] + [RVUpe-fac * GPCIpe * FEI] + [RVUm * GPCIm]) * CF

MPFS Non-Facility Payment =
([RVUw * GPCIw] + [RVUpe-nf * GPCIpe * FEI] + [RVUm * GPCIm]) * CF

In these formulas:
- RVUw equals the physician work relative value,
- RVUpe equals the practice expense relative value (fac = facility and nf = non-facility),
- RVUm equals the malpractice relative value,
- GPCIw is the physician work geographic practice cost index,
- GPCIpe is the practice expense geographic practice cost index,
- GPCIm is the malpractice geographic practice cost index, and
- FEI is the facility-employed adjustment factor.

The ACS continues to have significant concerns regarding how such an adjustment factor would be established given CMS' lack of data and its failure to recognize the additional costs associated with

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supporting services provided by an employed physician. Nevertheless, this approach would more effectively address potential cost differentials without unjustly denying resource payments for either facility or non-facility claims from physicians who are not hospital-employed.

- **Option B: Employed physician modifier and third PE RVU component.** CMS could develop a new modifier—such as "FE" for "facility-employed" physician—that would be appended to claims for services furnished by physicians who are employed by the facility in which they provided the services billed. The Agency could then create a third PE RVU column specific to employed physicians, in addition to the existing facility and non-facility PE RVU columns. When modifier "FE" is reported, payment would be determined using the new third column of PE RVUs for employed physicians.

We believe that either approach would allow CMS to more narrowly target the duplicative indirect PE payments that the Agency believes exist without erroneously altering values for the full spectrum of services rendered in either the facility or non-facility setting by non-hospital-employed physicians. Approaches such as those offered above would also ensure that physicians are not wrongfully impacted by a policy that is ultimately meant to address the indirect PE costs that hospitals incur and are paid for under the OPPS. These options would also maintain the RVUs assigned to facility services, which would avoid disrupting RVU-based physician employment contracts. Furthermore, both approaches align with MedPAC's recent recommendations to analyze clinician affiliation data and implement claim-based identifiers associated with a physician's primary practice setting (e.g., facility-based, non-facility-based, combined) to better align indirect PE payments with actual resource use.[1]

The ACS strongly urges CMS not to finalize the proposed broad reduction of indirect PE RVUs for all facility-based services in the CY 2026 MPFS. This proposal lacks a data-driven foundation, excessively broadens the scope of payment adjustments, and threatens to distort relativity within the MPFS. **We recommend that the Agency take the following actions:**

1) **Fully withdraw the facility indirect PE proposal and instead conduct a comprehensive review to determine whether true cost differentials exist in indirect PE when physicians are employed by hospitals. If such differentials are identified, CMS should publicly publish a rigorous, data-based quantification.**
2) **Collect and analyze more robust data encompassing physician employment status, facility affiliation, and actual overhead cost differences across a wide range of practice configurations.**
3) **Develop a more targeted policy framework if a data-supported cost differential is established, such as the introduction of a specific employment modifier alongside an employment adjustment factor or separate PE RVU column for employed physicians.**
4) **Allocate savings from any changes based on these considerations toward the MPFS CF to minimize unintended consequences for physician payment, promote equitable distribution of Medicare resources, and support the viability of independent physician practices.**

Payment for Medicare Telehealth Services

Provider Home Address Reporting Requirements

While the Agency did not address this issue in the proposed rule, the ACS requests that CMS permanently eliminate its requirement that providers update their enrollment records and list their home address on claims forms when performing telehealth services from their residences or other clinically-appropriate sites, consistent with flexibilities that have been in place since the

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public health emergency (PHE) for COVID-19 but are set to expire at the end of 2025. Listing a provider's home address on claims or enrollment documents would make such details *publicly accessible* on websites like CMS Care Compare and the Medicare Physician & Other Practitioners by Provider and Service online dataset. In addition, if a provider's home address is listed as the place of service, patients searching public directories may mistake it for a physical practice location, possibly leading them to travel to the provider's home—this is especially problematic for "hybrid" providers who work both from home and office settings. To protect providers' personal information and reduce patient confusion about practice locations, we encourage the Agency to develop an alternate method of determining location, such as using a zip code as an indicator for payment adjustment by geographic cost and wage index, for reporting purposes.

Evaluation and Management (E/M) Visits

E/M Visit Complexity Add-On

The ACS urges CMS to revisit its utilization assumption for Healthcare Common Procedure Coding System (HCPCS) add-on code G2211, which was established to recognize complexity of patient-physician relationships that involve a continuous, long-term commitment to the care plan. Per 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 RVUs. To determine the budget neutrality adjustment needed for G2211, the Agency was required to develop an estimate of how frequently G2211 would be billed in 2024. CMS stated its assumption that G2211 would be reported with 38 percent of all office/outpatient E/M visits in 2024—however, instead of being reported with 38 percent of all office visits, 2024 Medicare claims data indicate that G2211 was reported with only approximately 11 percent of office visits, which falls far below the Agency's estimate.

Because G2211 was implemented in a budget neutral manner and was expected to significantly increase Medicare spending, it triggered an excessive and unwarranted cut to the CF. Specifically, in the CY 2024 MPFS final rule, this adjustment reduced the CF by 2.18 percent, while the 2024 claims data suggest this reduction should have been only 0.79 percent. As a result, this cut was three times greater than necessary, improperly eliminating $1 billion from Medicare payment to physicians. **We urge CMS to correct its utilization estimate for G2211 based on actual claims data from 2024 and make a prospective budget neutrality adjustment to the 2026 CF in the forthcoming CY 2026 MPFS final rule.**

Valuation of Specific Codes

Proposed "Efficiency Adjustment"

CMS proposes to establish an "efficiency adjustment" to the work RVUs, as well as corresponding updates to the intraservice portion of physician time inputs, for non-time-based services. The Agency proposes that the "efficiency adjustment" would be calculated as the sum of the final productivity adjustments used in the Medicare Economic Index (MEI) for the prior five years—this calculation results in a proposed "efficiency adjustment" of -2.5 percent for CY 2026. CMS proposes to apply the "efficiency adjustment" to the intraservice portion of physician time and to work RVUs every three years.

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CMS' Assumption about Efficiency is Flawed and Not Supported by Data

The Agency states that non-time-based services become more efficient as the services become "more common, professionals gain more experience, technology is improved, and other operational improvements are implemented."[2] CMS' proposal is "based on its assumption that both the intraservice portion of physician time and the work intensity (including mental effort, technical effort, physical effort, and risk of patient complications) would decrease as the practitioner develops expertise in performing the specific service."[2] This assumes efficiency for an individual physician longitudinally but is proposed to be applied in a cross-sectional manner by the Agency.

CMS' assumption about efficiency is inherently flawed—the average operative times for most surgical Current Procedural Terminology (CPT) codes have remained the same or increased instead of becoming shorter over time. A recent peer-reviewed study published in the *Journal of the American College of Surgeons* (JACS) analyzing over 1.7 million operations, spanning 249 CPT codes and 11 surgical specialties, found that 90 percent of CPT codes had the same or longer operative times in 2023 compared to 2019. Additionally, operative times increased overall by 3.1 percent.[3] Another study shows an increase in operative time and complexity for 10 common general surgery procedures due to obesity.[4] A third study found no evidence that the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) systemically over or underestimates procedure times, which further supports the argument against an across-the-board "efficiency" cut.[5]

Another glaring error in this proposal is the premise that these services will continue to become more efficient indefinitely. Every physician has not achieved the same level of efficiency, nor is their expertise static. Newly trained physicians might take longer than more experienced physicians to furnish a given procedure. Similarly, experienced physicians who take on challenging cases or are teaching other physicians who are new to the procedure will require more operative time. This "cycle of experience" is ongoing. It is incorrect to assume that all physicians are at the same level of experience and simultaneously become equally efficient. In addition, the RUC process already addresses work RVU efficiencies when recommending work RVUs for codes that are "re-reviewed." **The overwhelming majority of codes presented to the RUC are valued at the 25th percentile of work RVUs rather than the median value offered by the presenting specialties**. An arbitrary across-the-board reduction is unwarranted and not supported by any evidence. New technology, while reducing time, can increase the intensity of a procedure. **Applying an "efficiency adjustment" now and/or every three years with no evidence and no end point is not supported.**

Procedures Are Being Performed on Older and More Complex Patients

Despite increased funding for primary care providers, there has not been a commensurate improvement in overall patient health outcomes. This trend can be attributed to the increasing clinical complexity within the patient population. While advances in medical technology and treatment protocols allow more patients to survive severe illnesses, these same patients often later require complex, high-risk surgical intervention after medical management has been exhausted or failed.

This evolving complexity of care is reflected in surgical practice. Highly experienced surgeons may improve time efficiency but undertake the most challenging cases, whereas newly trained or teaching

[2] 90 FR 32352
[3] Childers CP, Foe LM, Mujumdar V, et al. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. *J Am Coll Surg*. 2025.
[4] Childers CP, Petty AM, Selzer DJ, Senkowski CK. Obesity and Work in Abdominal Surgery. *J Am Coll Surg*. 2025;241(3):357-363.
[5] Chan DC, Huynh J, Studdert DM. Accuracy of Valuations of Surgical Procedures in the Medicare Fee Schedule. *N Engl J Med*. 2019;380(16):1546-1554.

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surgeons may treat less complicated patients but typically require more time. Valuation is based on time ***and*** complexity/intensity—not just time alone. It is noteworthy that valuation remains anchored to the "typical" patient—most often, this reflects patients whose clinical course (perioperative and operative) is straightforward. However, most patient populations are more heterogeneous, and correct valuation would require creating distinct codes for straightforward versus complex patients. For example, if 70 percent of procedures involve routine, short-stay cases, and 30 percent involve prolonged admissions, surgeons managing the latter group are never fairly compensated for the additional complexity and time required to handle the perioperative course of treatment, effort to document, and deal with advanced equipment. Similarly, there is no value built in for the experienced surgeon who may provide efficiency but also wisdom, and instead this factor would simply punish those surgeons even further.

Under the current coding framework and fee-for-service (FFS) model, especially with facility-only codes that have more than 50 percent outpatient status, surgeons delivering inpatient care frequently provide uncompensated services. They are unable to code for increased effort stemming from higher complexity, acuity, comorbidities, and/or time. By contrast, primary care providers benefit from additional billing opportunities—they can report multiple care management and remote monitoring codes and higher-level E/M codes, reflecting the time and/or complexity spent with each patient. The G2211 add-on code, for example, allows primary care providers to be compensated for the complexity of maintaining a longitudinal relationship with their patients.

In addition to analyzing operative time, the recent *JACS* study examined patient complexity, including preoperative risk factors (e.g., age, comorbidities), and 30-day morbidity and mortality and found that all measures of complexity increased over the study time period, without a change in operative mortality.[3] Another study concludes that obesity is a growing challenge in abdominal surgery and is associated with an increase in operative time and risk of complications.[5] A recent study of appendectomy cases found that 25 percent of cases had complicated disease, which was associated with increased operative time.[6] Through its actions and policies—including the implementation of add-on code G2211 and increases in the work RVUs for office and other outpatient E/M visit codes—CMS has explicitly recognized that patients present with greater complexity and require additional resources. However, this complexity is not confined to patients in primary care settings. Many of these same high-acuity patients ultimately require surgical intervention, underscoring the need for recognition of their resource intensity across the continuum of care, including the operating room.

The Agency points to the lag between RUC reviews, along with concerns about survey data, to justify an "efficiency adjustment," yet surgical patients are increasingly complex, and most surgical codes lack the tiered complexity levels found in E/M codes to reflect that reality. **Reducing a code's work RVUs simply because it has not been recently reviewed ignores the possibility that its value may actually be unchanged—or higher—given increased patient complexity and intensity.**

Global Codes are Already Devalued

We emphasize that 10- and 90-day global codes have already been systematically devalued, and applying an additional "efficiency adjustment" to these codes constitutes an unjustified further reduction. Prior to adoption of the RBRVS, physician payment was based on "usual and customary" charges, which did not account for resource use, time, or practice expenses. The shift to the RBRVS immediately rebalanced payments across specialties. Early simulations projected that payments for surgical services would decline by approximately 16 percent under the new fee schedule, while

[6] Childers CP, Selzer DJ, Green ML, Sutherland MJ, Senkowski CK, Mabry CD. Generating a New *CPT* Code Set for Adult and Pediatric Appendectomy. *JAMA Surg.* Published online August 20, 2025.

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payments for visits and consultations would rise by 27 percent.[7] The Health Care Financing Administration projected five-year payment increases of 30 percent and 29 percent for family practice and general practice, respectively, contrasted by decreases of 7 percent for general surgery and 14 percent for thoracic surgery.[8]

More recently, in the CY 2021 MPFS, CMS increased the values for office and outpatient E/M visits but failed to apply corresponding adjustments to the E/M services included within global surgical codes.[9] Similarly, when the Agency approved increases to hospital inpatient and observation services for CY 2023, the corresponding adjustments within global surgical codes were not applied. This deliberate departure from precedent in CYs 2021 and 2023 resulted in a disproportionate devaluation of global codes and created specialty-specific payment inequities that run contrary to Medicare statute. Implicit in CMS' current policy is the unfounded assumption that an E/M visit performed within a global surgical period requires less physician work than the same visit billed discretely. **Applying an "efficiency adjustment" to global codes—already subjected to cumulative devaluation—lacks both evidentiary support and statutory justification.**

Implementation Concerns

We also have implementation concerns with the proposed "efficiency adjustment" policy, described below.

- **Newly Created, Recently Revalued, Low Volume, and Time-Based Codes.** CMS proposes to apply an "efficiency adjustment" to codes that have already been reviewed by both the RUC and the Agency within the five-year lookback period, including codes currently under consideration for revaluation. It is unclear how efficiency gains could reasonably be attributed to new or revised codes that have never been billed, or why CMS would apply a five-year lookback adjustment to codes that have already undergone review within that timeframe. Additionally, low-volume codes do not meet the Agency's own stated criteria for efficiencies, as such services are not performed frequently enough to realize measurable gains. Finally, we note that CMS' proposed list of affected services includes time-based codes, despite the Agency's stated intention to exempt these codes. **Applying an "efficiency adjustment" across the board—including to new or revised, recently revalued, and low-volume surgical codes—without demonstrated efficiencies lacks statutory basis and must not be adopted.**

- **E/M Services.** CMS proposes not to apply the "efficiency adjustment" to E/M services, reasoning that the resources required for the work portion of these services are primarily determined by the clinician's time with the patient and therefore not amenable to efficiency gains. The ACS has, on public record, recommended the development of a new modifier that would indicate that an E/M service was based on time for the purpose of being able to audit E/M services claims. Both the Agency and the CPT Editorial Panel rejected this request. However, we assert that most E/M services are billed using medical decision-making and are not using time because of the burden to document both face-to-face and non-face-to-face time.

  The Agency further asserts that because E/M valuation is not responsive to efficiency, these services are passively devalued over time under budget neutrality. **We disagree. Many of the rationales CMS cites for applying "efficiency adjustments" to other services—including high utilization,**

[7] 55 FR 36200; See also, 56 FR. 700
[8] 56 FR 59618
[9] Childers CP, Hu CY, Swisher SG, Wong SL, Chang GJ. Estimated Financial Impact of 2021 Office-Visit Work Relative Unit Updates on Surgical Global Periods. *JAMA Surg*. 2024;159(9):1087-1089.

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professional experience, advances in technology, and operational improvements—apply equally to E/M services. For example, utilization of E/M codes remains by far the highest in the fee schedule, making them at least as common as other codes that would be subject to an "efficiency adjustment." Moreover, there is no evidence that clinicians performing procedures and other non-E/M services are achieving greater efficiencies than those who furnish E/M services. Technological innovations, such as artificial intelligence (AI)–based medical scribes, are increasingly adopted across medicine (with primary care among the highest adopters) and have demonstrated substantial reductions in time burden and cognitive load. [10] A study of the impact of digital scribes showed that the digital scribe was 2.7 times faster than both typing and dictation. For the physical exam section of the documentation specifically, the digital scribe was 2.17 times faster than typing and 3.12 times faster than dictation with minimal training.[11] Operational improvements also impact E/M delivery just as much, if not more, than non-E/M services. It is also notable that while CMS justified increasing the value of standalone E/M services on the grounds that patients are becoming more complex, the same reasoning was not applied to E/M services embedded in global codes. This creates an inconsistency in policy. **The same factors the Agency identifies as driving efficiency in non-E/M services apply equally to E/M services.**

Unintended Consequences

The impact of the "efficiency adjustment" extends well beyond the adjustment to work RVUs for non-time-based Medicare services. The proposed "efficiency adjustment" may be perceived by Medicare beneficiaries as CMS urging surgeons to rush through procedures. Patients want surgeons to take as long as medically necessary to safely complete a procedure. Hospitals and health systems may also place pressure on physicians to avoid the sickest, most complicated patients who will take more time to treat. The landmark Institute of Medicine report from 1999, "To Err Is Human: Building a Safer Healthcare System," stressed the importance of avoiding excessive pressure on physicians that can lead to fatigue and errors.[12] While this report is over 25 years old, it is critical to remember important lessons learned about our healthcare system from this and patient safety failures over the years. By lowering the relative value of these services, physicians may face financial pressure that discourages them from caring for the sickest and most complex patients who require significantly more time and resources. If work RVUs drop below sustainable levels, access to care for these vulnerable patients will inevitably be threatened.

We are deeply concerned with the misaligned incentives of this policy, and we do not believe that CMS intends for these unavoidable consequences to become a reality. The Agency seems intent on paying for the "fastest" surgery rather than the high-quality surgery that Medicare beneficiaries deserve and should be provided at levels to ensure adequate resources for patients of varying levels of complexity. As stated in the 2025 Medicare Trustees Report, "The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large." Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term. CMS' "efficiency adjustment" proposal will only compound the issues that the Trustees have already well-identified.[13]

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[10] Tierney AA, Gayre G, Hoberman B, et al. Ambient Artificial Intelligence Scribes: Learnings after 1 Year and over 2.5 Million Uses. *NEJM Catal Innov Care Deliv*. 2025;6(5).
[11] Wang J, Lavender M, Hoque E, Brophy P, Kautz H. A patient-centered digital scribe for automatic medical documentation. J Am Med Inform Assoc. 2021;4(1).
[12] Institute of Medicine (US) Committee on Quality of Health Care in America, Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err is Human: Building a Safer Health System*. Washington (DC): National Academies Press (US); 2000.
[13] Board of Trustees of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. The 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. June 18, 2025. Accessed August 28, 2025. https://www.cms.gov/oact/tr/2025.

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Implementing recurring reductions to work RVUs every three years would have severe consequences for physician compensation. Many physician employment contracts are based on work RVUs or total RVUs, meaning that reductions in these values will decrease physician compensation despite no reduction in actual work performed. Physicians who have already entered into multi-year contracts could find themselves locked into compensation arrangements that are no longer viable, without the opportunity to renegotiate in response to these unexpected changes. Looking ahead, the inability to anticipate the magnitude of future RVU reductions introduces ongoing uncertainty, making it increasingly difficult to structure fair and sustainable employment agreements. This instability also extends to private practice and solo practitioners, who would face yet another layer of financial unpredictability. We strongly urge CMS to recognize these far-reaching, unintended consequences and to reconsider this policy in light of its harmful effects on patients, physicians, and the broader healthcare system.

Summary

If CMS is concerned about efficiency, we urge the Agency to only make changes to specific codes with empirical evidence showing that they have become more efficient. Given the absence of such evidence, we support the current use of RUC surveys to review and recommend relative values for codes. Research demonstrates that RUC surveys and objective data do not exhibit systemic bias relative to one another.[4] We specifically urge CMS to refrain from making broad, across-the-board reductions to work RVUs for the reasons discussed above. Finally, we strongly recommend that the Agency consider implementing a modifier or HCPCS G-code for surgical complexity. With a complexity modifier, surgeons will be able to identify the cases that are more complex and/or patients who are inherently sicker. This will more directly and appropriately address CMS' interest in isolating the cases that are truly more efficient. **The Agency should not move forward with finalizing the proposed "efficiency adjustment" because CMS' assumption that all non-time-based codes have decreased in time is inherently flawed. In addition, it is not appropriate to impose an across-the-board work RVU reduction, especially given the lack of empirical evidence for this assumption.**

Valuation of Specific Codes for CY 2026

Lower Extremity Revascularization (CPT codes 37XX1, 37X02, 37X03, 37X04, 37X05, 37X06, 37X07, 37X08, 37X09, 37X10, 37X11, 37X12, 37X13, 37X14, 37X15, 37X16, 37X17, 37X18, 37X19, 37X20, 37X21, 37X22, 37X23, 37X24, 37X25, 37X26, 37X27, 37X28, 37X29, 37X30, 37X31, 37X32, 37X33, 37X34, 37X35, 37X36, 37X37, 37X38, 37X39, 37X40, 37X41, 37X42, 37X43, 37X44, 37X45, and 37X46). In October 2018, CPT codes 37225, 37227 and 37229 were identified by the RUC's Relativity Assessment Workgroup PE High-Cost Supplies screen for services with non-facility Medicare utilization over 10,000, which were not reviewed in the last five years and include a supply item greater than $500. The applicable specialty societies worked with the CPT Editorial Panel and submitted multiple code change applications over several years. In September 2024, the CPT Editorial Panel created four new subsections and 46 new codes to report lower extremity revascularization (LER) services, and the 16 existing codes (37220-37235) to report these services were deleted. **The ACS appreciates CMS' proposal to accept the work value recommendations as proposed for all 46 codes in the LER code family.**

Practice Expense

CMS disagrees with the RUC-recommended direct PE inputs for LER and revises the quantity allocations for drug-coated balloons (SD382) and tibial drug eluting stents (SD379). **We object to the Agency's perceived "discrepancies" regarding the number of allocated units of these two high-cost**

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supply items and believe that the RUC's recommendations reflect the actual resources used for the different services based on large anatomic variation in length between the vessels, as well as the typical length of the arterial disease in the vessels located in the four vascular territories described by this family of codes. Such differences in quantity do not represent an inconsistent allocation strategy, but rather an accurate depiction of a complex combination of additive or conjunctive treatments. **The ACS urges CMS to accept the RUC-recommended direct PE inputs for all 46 new CPT codes.**

- **Drug-Coated Balloons (SD382).** CMS states that "the RUC documentation specifies two units for the initial vessel and one unit for additional vessels in CPT codes 37X10-37X13 and 37X18-37X21. However, for CPT codes 37X14-37X15 and 37X22-37X23, only one unit is listed for the initial vessel." The Agency proposes updating the initial vessel quantities to one unit of SD382 for CPT codes 37X10, 37X12, 37X18, and 37X20, while maintaining one unit for additional vessels. **We disagree with CMS' proposal and believe that the quantity allocations for drug-coated balloons as recommended by the RUC are correct.**

  The surveying specialty societies and the RUC agree that CPT codes 37X10, 37X12, 37X18 and 37X20 would typically require two drug-coated balloons, whereas their corresponding add-on codes (37X11, 37X13, 37X19 and 37X21) would typically only require one drug-coated balloon for each additional vessel. For the base codes, surgeons typically treat the superficial femoral artery and popliteal artery, which is considered one segment, and that segment is much longer than the common femoral artery or the profunda femoris. **It is typical to have multifocal or long-segment disease in the superficial femoral artery and popliteal artery segment where one drug-coated balloon—which, per U.S. Food and Drug Administration (FDA) instructions for use, can only be used once to deliver its therapeutic payload upon one area during a single inflation—will not be adequate to treat the whole area.**

  For CPT codes 37X14, 37X15, 37X22, and 37X23, only one unit was recommended for the initial vessel, as these codes describe femoropopliteal angioplasty or femoropopliteal atherectomy for treatment in the common femoral or profunda femoris segments of the femoropopliteal region, which are much shorter vessels and therefore have shorter disease segments. This lower quantity allocation for these add-on codes does not represent a "discrepancy," but rather the appropriate course of treatment of the typical scenario for such codes. It would be most typical to report CPT codes 37X14, 37X15, 37X22, and 37X23 for the common femoral artery or the profunda femoral artery segment, which are short enough that surgeons can treat them with one drug-coated balloon. **The ACS urges CMS to accept the RUC-recommended direct PE inputs for CPT codes 37X10, 37X12, 37X18, and 37X20 and restore the number of drug-coated balloons (SD382) to two per code.**

- **Tibial Drug Eluting Stents (SD379).** CMS states that "the RUC recommends a quantity of two for supply code SD379 (drug eluting stent, tibial) for four CPT codes in the tibial and peroneal vascular territory, CPT codes 37X33, 37X34, 37X41, and 37X42. The RUC-recommended quantity exceeds the number of units of supply code SD266 (stent, self-expanding 2-5 mm XPERT (Abbott)) currently used in CPT code 37230, 37234, 37231, and 37235, respectively." The Agency proposes to reduce the quantity from two to one for supply code SD379 in each of the four CPT codes 37X33, 37X34, 37X41, and 37X42. **We disagree with CMS' proposal and believe that the quantity allocations for drug eluting stents as recommended by the RUC are correct.**

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The utilization of tibial stents has expanded due to an increase in the availability of advanced techniques, the improvement in the quality and availability of drug eluting stents, and the expanding utilization of endovascular procedures in the treatment of limb threatening ischemia. At the time that the Xpert stent was listed as the PE supply input for tibial stenting, it was the only product available with the sizes appropriate for tibial vessels. Since the time that the previous code set was valued, Xpert stents have been removed from the market and are no longer used. It is inappropriate for CMS to base its proposal on the previous number of supply inputs for a new, expanded code set.

The surveying specialty societies and the RUC agree that CPT codes 37X33 and 37X34, which describe tibial angioplasty and stent placement in complex lesions, typically require the use of two drug eluting stents due to the length of the lesions and the underlying heavy calcification commonly associated with this pathology, whereas tibial segment straightforward codes 37X31 and 37X32 only require one drug eluting stent each. In general, surgeons would only use stents where they determine they must maintain the vessel's patency. For a straightforward lesion, a stent is usually only needed in one location, but for complex lesions, the occlusive disease is typically quite long. The length of the vessel is the same between a straightforward and a complex lesion for 37X31-37X34; however, for tibial interventions, the longest available drug eluting stent approved by the FDA for use in such vessels is 38 millimeters, while the typical length of a tibial artery is 250-300 millimeters. It is most typical to use two stents in the tibial segment for complex lesions, with surgeons using four or five stents in the tibial segment in edge cases. CPT codes 37X41 and 37X42, which describe tibial atherectomy, angioplasty, and stent placement in complex lesions, require the use of two drug eluting stents for the same reasons. **The ACS urges CMS to accept the RUC-recommended direct PE inputs for CPT codes 37X33, 37X34, 37X41, and 37X42 and restore the number of drug eluting stents (SD379) to two per code.**

Supply Pack Assignment for Angiography Services

The ACS thanks CMS for establishing a new supply pack for angiography services (SA142) as part of the LER code set. **However, we believe that the Agency did not assign SA142 to the applicable codes in the proposed rule.** There are 22 new LER codes for which this pack should be used. The purchase price of $68.26 equates to the individual components of the pack, shown in the table below. **As such, the ACS requests that SA142 be assigned to the following CPT codes: 37XX1, 37X03, 37X05, 37X07, 37X10, 37X12, 37X14, 37X16, 37X18, 37X20, 37X22, 37X24, 37X27, 37X29, 37X31, 37X33, 37X35, 37X37, 37X39, 37X41, 37X43, 37X45.**

TABLE 1. Angiography Supply Package (SA142)

Angiography Pack Contents	Supply Code	Corresponding Supply List Components	Price Per Unit	Units	Purchase Price ($68.26)
10 cc syringe	SC051	Syringe 10-12ml	0.21	4	$ 0.84
Control syringe (lidocaine)	SC051	Syringe 10-12ml	0.21	1	$ 0.21
Bowl, sterile	SJ079	Basin, sterile 500cc	3.51	2	$ 7.02
Gauze	SG055	Gauze, sterile 4in x 4in	0.19	20	$ 3.80
Marker, regular tip	SK075	Skin marking pen, sterile (Skin Skribe)	1.62	1	$ 1.62
Dome cover	SB008	Drape, sterile, c-arm, fluoro	5.38	1	$ 5.38
Blue towels	SB019	Drape-towel, sterile 18in x 26in	0.47	4	$ 1.88
Scalpel	SF007	Blade, surgical (Bard-Parker)	0.68	1	$ 0.68
Back table cover	SB014	Drape, sterile, three-quarter sheet	3.46	1	$ 3.46
20 cc syringe	SC053	Syringe 20ml	0.83	4	$ 3.32
Drape, femoral	SB009	Drape, sterile, femoral	9.15	1	$ 9.15

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Medicine cup	SL157	Cup, sterile, 8 oz	0.58	1	$ 0.58
Label sheet	SL198	Label, vial	0.02	9	$ 0.18
Scissor	SA027	Kit, scissors and clamp	0.82	1	$ 0.82
Surgical gowns x 2	SB028	Gown, surgical, sterile	5.13	2	$ 10.26
18 G needle	SC027	Needle, 18-19g, filter	0.21	1	$ 0.21
25 G needle	SC028	Needle, 18-26g 1.5-3.5in, spinal	9.96	1	$ 9.96
Needle counter	SD120	Styrofoam block, high density (3in-12in-12in)	1.86	1	$ 1.86
Towel clamps (plastic disposable)	SD208	Towel clamp, plastic	0.76	4	$ 3.04
Guidewire bowl	SD171	Guidewire bowl w-lid, sterile	3.99	1	$ 3.99

Strategies for Improving Global Surgery Payment Accuracy

CMS does not propose immediate policy changes but seeks comment on whether the "procedure shares" for global codes should be recalculated using a new methodology. The Agency outlines and solicits feedback on three potential methods for recalculating the procedure shares for 90-day global surgery packages. We agree with CMS that real-world practice patterns and the ability to update global codes more routinely could lead to more accurate procedure share assignments, but we do not support any of the three approaches that the Agency puts forward for the reasons described below. **The ACS therefore urges CMS to maintain the current assignment of procedure shares based on historical assumptions.**

1. ***Procedure work RVUs would be calculated by subtracting the RVUs assigned to each postoperative visit listed in the physician time file from the total work RVUs for the global package.***

The Agency's first potential method uses a reverse building block methodology to calculate procedure work RVUs. We only support the review of codes and the determination of procedure shares using relative valuation, not a building block or reverse building block valuation approach. CMS has noted in prior years that the Agency was unclear whether it would be appropriate to treat the E/M visits reflected in the global packages as discrete components of the package (i.e., using a building block approach instead of magnitude estimation). The E/M visits reflected in the global packages are indeed discrete components but are valued using magnitude estimation, not as discrete components. Therefore, subtracting RVUs assigned to postoperative E/Ms is not an appropriate approach to calculating procedure work RVUs. Furthermore, CMS has itself made this approach unusable through its "efficiency adjustment" proposal, which, if finalized, would undermine the utility of all the values in the file for determining relative value shares of the global package for these purposes. The Agency has also made other choices that undermine the utility of this approach for determining procedure shares: CMS' inappropriate decision to translate the recent revaluations of office and outpatient E/Ms and inpatient E/Ms to global packages has not only undermined the relativity of the entire fee schedule, but in doing so, it has made the work RVU approach for calculating procedure shares unreliable. These files are now anchored in data that are distorted by the Agency's failure to properly apply the revaluations of E/Ms to the global periods.

2. ***Procedure work RVUs would be calculated by subtracting the work RVUs for postoperative visits actually reported to CMS using CPT code 99024. CMS would use the median number of reported 99024 visits for the procedure and multiply by the average RVU per visit, based on time and level in the physician time file.***

CMS' second potential method uses CPT code 99024 data collected by the RAND Corporation. The Agency contracted with RAND to develop a process and to collect and analyze 99024 data, but RAND's process was poorly structured, difficult for practices to operationalize, and the analysis relied on flawed

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and incomplete data that were never validated. One inherent flaw in the RAND data collection methodology was that it was not possible to capture postoperative visits provided in the inpatient setting since 99024 carries no charge and were often scrubbed by billing software. This shortcoming destroys the accuracy and validity of the model and makes it unreliable. We strongly oppose any revaluation or changes to procedure shares based on incomplete and unvalidated data found in the RAND reports or based on the 99024 data that RAND collected. The Department of Health and Human Services Office of Inspector General (OIG) has also issued a recent report documenting that the CMS/RAND 99024 data collection effort severely undercounted the number of postoperative visits actually furnished relative to the Agency's data, essentially rendering the 99024 data useless for purposes of accurately developing procedure shares. [14]

3. Procedure work RVUs would be calculated by multiplying the total physician time (in minutes) by the proportion of that time spent on the procedure itself (i.e., excluding time for post-op visits), based on the physician time file.

CMS' third potential method arrives at the procedure share using a work per unit time approach, which assumes the intensity of the encounter is consistent throughout the operation and through 90 days postoperatively. This method is unsupported by empirical evidence and is dismissive of the knowledge and skills of the surgical community. The time a surgeon spends performing a high-risk, technically demanding procedure—such as meticulously dissecting the artery that supplies blood to the brain—is not equivalent to the time spent counseling the patient prior to the operation or providing postoperative care. The Agency's continued insistence on imposing a simple formula to "fix" a system that has been refined over more than three decades with thousands of hours of expert input is deeply flawed and threatens to undermine the accuracy of the MPFS. Eliminating postoperative time from the work RVU calculation and assuming the remaining time sufficiently captures surgical intensity is not only inappropriate, but dangerously undervalues complex surgical services. This approach would disproportionately penalize high-intensity procedures and risks jeopardizing patient access to critical, life-saving surgical care.

Policies to Improve Care for Chronic Illness and Behavioral Health Needs

Comment Solicitation on Payment Policy for Software as a Service (SaaS)

CMS discusses challenges in accounting for services that include innovative technology, such as software algorithms and AI, in the Agency's PE methodology. CMS expresses concern about the rapidly changing nature of technology, along with difficulties in obtaining verifiable and consistent costs from manufacturers and seeks feedback on the questions below.

1. What factors should CMS consider when paying for SaaS?

We urge CMS to consider the following factors when paying for SaaS:

- **Subscription-Based Model.** SaaS is usually subscription-based (e.g., monthly, annual), not a one-time capital purchase. Payment structures should reflect ongoing costs, not amortized equipment.
- **Scalability and Utilization.** SaaS costs can scale up or down based on practice size or provider usage levels. Payment models should be flexible rather than static across all practice sizes.

[14] Office of Inspector General. CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries. June 2025. A-05-20-00021. Accessed August 28, 2025. https://oig.hhs.gov/documents/audit/10428/A-05-20-00021.pdf.

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- **Security, Updates, and Maintenance.** Costs for cybersecurity, ongoing software updates, support, and regulatory compliance (including the cost of monitoring SaaS-based tools) are fundamental parts of SaaS pricing and should be recognized as part of the allowable expense.
- **Interoperability and Integration.** The resource costs of electronic health record integration, onboarding, application programming interface/interface development, and provider training are significant and commonly under-recognized.
- **Data Management.** SaaS pricing should reflect not only functionality but also the value of data management, analytics, and decision support, including AI.
- **Shorter Technology Lifecycles.** SaaS technology evolves quickly; payment models should account for periodic technological obsolescence or rapid upgrades, not just depreciation over multiple years.

2. ***Given the limitations of PE methodology, what alternative pricing strategies should CMS use for SaaS and AI under PFS?***

When paying for SaaS, the Agency should move away from traditional direct PE equipment formulas and instead create a distinct valuation methodology for SaaS that captures recurring subscription costs, implementation/onboarding, and usage-based fees. CMS could also explore linking SaaS payment to usage or outcomes delivered (e.g., improvements in chronic care, diagnostic speed, error reduction), rather than just inputs or time. Surveys of actual commercial SaaS contract rates across a cross-section of provider types/size could also be informative.

3. ***Is there an alternative data source to current Medicare claims and manufacturer invoices to more accurately reflect SaaS costs?***

We offer a few alternative data source options for the Agency to consider when determining SaaS costs below.

i. CMS could use third-party market research/industry benchmarks for research on SaaS costs in health care.
ii. CMS could collect cost reports from practices that would voluntarily report SaaS expenses in Medicare cost report supplements. This effort could in part be facilitated by professional medical societies.
iii. CMS could administer a standardized provider SaaS/AI technology cost survey to be submitted annually by practices for gathering data on SaaS costs.

OTHER PROVISIONS OF THE PROPOSED RULE

Ambulatory Specialty Model (ASM)

AMBULATORY SPECIALTY MODEL

Under the authority of the Center for Medicare and Medicaid Innovation (CMMI, or the Innovation Center), CMS proposes the implementation and testing of the Ambulatory Specialty Model (ASM), a new mandatory alternative payment model (APM) with 5 performance years that would begin January 1, 2027, and end December 31, 2031. The proposed model is designed to enhance quality of care and reduce costs for Medicare beneficiaries with the chronic conditions of heart failure or low back pain. It would evaluate whether linking specialist payments to performance on measures related to quality, cost, care coordination, and meaningful use of certified electronic health record technology (CEHRT) can

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lead to more effective upstream chronic condition management. Under the model, participating clinicians will receive neutral, negative, or positive payment adjustments to future Medicare Part B payments based on their performance, while continuing to bill under traditional FFS. Clinicians in ASM would be exempt from Merit-based Incentive Payment System (MIPS) reporting requirements during their participation. Unlike MIPS, which is a budget neutral program, the Agency would retain a portion of the funds available for payment adjustments as Medicare savings instead of distributing the full amount to participants.

While the ASM uses the MIPS Value Pathway (MVP) framework, it differs in several ways:

- ASM participants will be required to report on a set of measures and activities meant to represent performance for the condition being evaluated and managed (and will not have the flexibility to select measures or activities as is the case with MVPs reported under MIPS).
- ASM will compare performance of only those clinicians treating the same condition (whereas under MVPs, clinicians are scored against the entire pool of MIPS clinicians).
- ASM will use a different methodology than MVPs in calculating a final score and ASM payment adjustment, placing more value on quality and cost performance.
- ASM participants will be required to report as individual clinicians (and will not have the option of reporting through a group as they do under MVPs and MIPS).

CMS notes that the model fits within the Innovation Center's larger framework of focusing on high-volume, high-cost chronic conditions and direct engagement of specialists in value-based payment models. The Agency believes by incorporating patient-reported outcome measures (PROMs) into clinician performance assessments, the model will incentivize clinicians to incorporate patient voice and experience in clinical care decisions to foster conversations around non-medical, lifestyle-based interventions with patients. CMS further highlights that it believes evaluating clinicians individually will encourage competition and create a level playing field for solo and small practices.

ACS Model Design Recommendations Overview

Overview

The ACS applauds CMMI for designing the ASM to be condition and procedural episode-specific. However, we have concerns regarding various limitations that we believe will greatly limit the success of the ASM. While we appreciate CMS' intent to implement a model that spans care for a condition that may or may not include a procedure, we believe that the current MVP framework is inadequate to achieve this goal. By setting the unit of analysis in the ASM at the individual physician-level, the Agency is further perpetuating the care silos that have plagued the MVP framework and Medicare FFS more generally. CMS has a long-held belief that measuring individuals within a teamwork environment will drive competition and improvement. When the care cycle depends on one physician in a single, brief care setting this may be true. When care relies on the interactions in systems with multiple inputs and role players, the evidence is to the contrary. **Therefore, the ACS recommends an overhaul of the ASM in terms of both the quality and cost metrics to better reflect the patient's experience of how the condition is treated. We recommend looking at the full care journey and the embedded care pathways to focuses on the "systemness" of the care with shared accountability across the entire care team. We urge the Agency to pause ASM implementation efforts and instead focus on model redesign using a quality and cost framework that goes beyond the limits of the current MIPS program.**

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As an alternative to the proposed ASM, CMS should consider working closely with stakeholders to create an episode-based model with the ability to 'nest' procedural episodes seamlessly into chronic care episodes. The ACS had previously proposed the ACS/Brandeis Advanced APM[15], a model that would also have allowed for the evaluation of procedural episodes nested within chronic care episodes through the use of a sophisticated episode grouper—a similar framework could be adapted to this task in an APM framework. The ACS and other stakeholders would welcome the opportunity to work closely with the Agency to achieve this goal.

Below we outline challenges with the proposed model design in greater detail and provide recommendations for future model design.

Challenges of Current Model Design

- **Individual clinician-level participation.** The ASM is fundamentally flawed by focusing on measurement at the individual level for a condition—this is contrary to how CMS and the Innovation Center should be thinking about care coordination and patient centricity. Measuring quality and cost at the level of the individual clinician will never achieve statistically reliable measurement and will always lack trust from the clinician community. Clinician-level reporting also significantly adds to administrative burden. When a surgeon or a facility is the unit of analysis, the impact on referral decisions is limited since most of the information is not episode-specific. It ends up being too general to be useful and primary care providers (PCPs) or patients do not find it helpful enough in their referral considerations. For example–how does a PCP or specialist determine where to refer a patient if one surgeon reports a level of surgical site infection (SSI) and readmission and another reports a variance in reoperations and PROs and most of these are rare occurrences? It is difficult to discern where to refer patients when reviewing lists of major complications that might have rarely occurred. Referring physicians wish to refer patients to surgeons affiliated with centers that report a low percentage of major harms in aggregate and good patient experiences. Perhaps these measures meet the needs of a numeric determination and ranking for payment, but they do not serve to generate an expression of comparative quality or drive improvement.

- **Using a one-size-fits-all approach to measurement**. While a one-size-fits-all approach to measurement may seem prudent and easier to implement in a payment model, it fails to capture the complexity of care furnished by specialists, such as surgeons. Such an approach is neither informative nor meets the needs of the various stakeholders included in the model. The ACS strongly supports models that evaluate performance at the episode level, which provides a more accurate and meaningful evaluation of care delivered as part of the patient's care journey, rather than isolating performance at the individual physician level.

- **Leveraging the failed MIPS/MVP measure framework.** The College strongly opposes MVPs or any MIPS measures for use in the ASM because they were built for a singular event in FFS and lack incentives for team-based care. MVPs have only reshuffled existing MIPS metrics and are still focused on single metrics for clinicians/specialties that do not map to the patient or the care team. To move physician payment incentives for quality and safety to a value-based program requires a change in measurement thinking. Model accountability should focus on how the team delivered on patient goals, if major complications were avoided, and when appropriate, if the facility has the right processes and structures to avoid minor complications and has the ability to rescue patients.

[15] American College of Surgeons. Proposal for a Physician-Focused Payment Model: ACS-Brandeis Advanced Alternative Payment Model. December 13, 2016. Accessed September 11, 2025. https://aspe.hhs.gov/sites/default/files/private/pdf/253406/TheACSBrandeisAdvancedAPM-ACS.pdf.

- **Tournament-style model design**. The tournament-style model discourages collaboration, primarily focusing on cutting costs, which is a race to the bottom. This methodology pits members of the team against each other rather than incentivizing organization around the patient.

- **Rethink Acumen cost measure methodology.** The existing MIPS cost measures are very narrowly defined, limiting their value for incentivizing reduction in cost within MIPS/MVPs. **Measures that recognize the team-based nature of care with shared accountability are more appropriate if we expect to optimize the total care expenditure.** The Acumen methodology is also not sophisticated enough to account for potential savings from more efficient or unnecessary care, thereby incentivizing more care. If clinicians are providing better care by providing less care, those savings are not realized.

- **Misaligned incentives impact all Part B payments.** For individuals in the ASM, payment reductions are applied to all Part B services, not just those related to what is being measured as part of the model. This further compounds concerns that the model could pull in specialists who see a relatively low volume of ASM conditions, yet all their Part B payments are at risk. If the Agency moves forward with this model, the ACS recommends that CMS reconsider the definition of the cohort for ASM participation to ensure that physicians whose Part B payments are at risk can meaningfully participate in the model.

- **Withholding funds for redistribution lowers incentives for high performers.** Because the Agency will withhold a portion of the funds available for redistribution as savings to the Medicare program, the incentives available to high performers are decreased. We see this as a major flaw in the incentive structure of the model and recommend that the CMS withhold be removed, making 100 percent of the funds available to ASM participants as part of the incentive pool. In later sections we outline our recommendations for a value-based payment model that will generate savings by improving efficiency and quality across an episode of care. We see this as a more meaningful path forward that will incentivize team-based, patient-centered care, that aligns with the care model and promotes resource savings.

- **Maximum risk under the model exceeds the maximum negative adjustment in MIPS.** By 2031, or ASM performance year 5, ASM participants would be subject to a maximum downside risk of -12 percent, which significantly exceeds the maximum negative payment adjustment in the MIPS program. This is concerning, especially since ASM will not qualify as an Advanced APM. The ACS recommends (1) that CMS implement a "glidepath" into the payment reductions, for example, not implementing negative risk for the initial two years of the model and (2) reduce the maximum risk.

ASM Quality Performance Category Considerations

The ASM considers a patient with a condition that involves the care of more than one or multiple physician specialties. While the ASM aims to look across the episode—a great start—it uses a traditional physician-centered MVP measure framework that results in a flawed focus on individual, siloed efforts. It is an every-physician-for themself approach to measurement and represents fragments of the care delivered. For value-based care to evolve, we must consider the care delivered by all those who play a role in the care of the patient, including the facility (when applicable), not only focusing on the individual roles in part using MIPS/MVP measures. The MVP framework is contrary to incentives that encourage the team to organize around a patient and focus on patient outcomes and goal achievement. The physician alone cannot carry the change needed for the transition to value.

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An alternative approach CMS should consider is working closely with stakeholders to create an episode-based model with the ability to 'nest' procedural episodes seamlessly into chronic care episodes. The ACS/Brandeis Advanced APM proposal,[15] which was submitted to and approved by the Physician-focused Payment Model Technical Advisory Committee (PTAC), could be adapted to this task in an APM framework. With this approach, shared attribution is assigned to all physicians who participate in the episode, and performance of the team is tracked across the entire course of care of the patient for that condition. This methodology can motivate the care team to work together to assure a culture of safe, high-reliability care. This framework offers more descriptive information to patients, in ways that are similar to how they would think of their care and are more helpful for referring clinicians and other stakeholders. **Ultimately, this results in a measure framework that considers the full program of care with the patient at the center and prioritizes shared accountability.**

It is also important to note that sharing attribution across the care team for the episode increases the volume of patients being measured to achieve a threshold that will help to mitigate the statistical challenges of "small numbers" and add more precision to the determination of differences. As mentioned above, measures at the individual clinician level run the risk of not having large enough case numbers, which could result in the Agency making inferences based on small sample sizes and over-interpretation of results.[16] However, using an episode measurement approach also allows for closer inspection of complications across an episode of care—this includes identification of major and minor complications that are often related to the execution of the care plan, technical aspects of care, judgment or clinical decisions and patient co-morbidities. Most CMS measurement systems currently focus on a single, high impact major complication, but the goal should be to avoid both major and minor complications. Using tools such as ACS National Surgical Quality Improvement Program (NSQIP) we see that major complications are rare and sometimes costly, often leading to other complications, while more frequent minor events are not as easily identified despite their high volumes. Minor complications that cause minimal harm can be readily reversed. However, while these are much less costly, minor complications are much more common and harder to track. A wealth of evidence backs up the premise that we should be moving toward measures that look at the system as a whole to prevent harms that can greatly increase costs and reduce patient safety and experience.[17, 18, 19, 20, 21, 22]

It is important to note the ASM as proposed will cover services which may or may not include inpatient or other facility-based care. **In cases where the condition episode includes facility-based procedures, we challenge the Agency to shift its quality focus to system-level reliability which can be measured through verification programs that support major and minor complications avoidance while focusing on patient goal achievement.** CMS does value episode verification systems in trauma programs, bariatrics and in maternity/neonatal with success, and therefore the Agency should extend to several other high impact, high-cost domains. Avoidance of minor complications requires a systems

[16] Six Sigma. Understanding the Central Limit Theorem In Quality Control. January 30, 2025. Accessed September 4, 2025. https://www.6sigma.us/six-sigma-in-focus/central-limit-theorem/.
[17] Office of Inspector General. Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018. May 5, 2022. OEI-06-18-00400. Accessed September 4, 2025. https://oig.hhs.gov/documents/evaluation/2997/OEI-06-18-00400-Complete%20Report.pdf
[18] Lawton EJ, Sheetz KH, Ryan AM. Improving the Hospital-Acquired Condition Reduction Program Through Rulemaking. JAMA Health Forum. 2020;1(5):e200416.
[19] Slankamenac K, Graf R, Barkun J, Puhan MA, Clavien PA. The comprehensive complication index: a novel continuous scale to measure surgical morbidity. Ann Surg. 2013;258(1):1-7. =
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[21] Cardell CF, Peters XD, Hu QL, et al. Evidence Review for the American College of Surgeons Quality Verification Part III: Standardization, Protocols, and Achieving Better Outcomes for Patient Care. J Am Coll Surg. 2024;239(5):494-510.
[22] Agency for Healthcare Research and Quality. Measure Dx: A Resource To Identify, Analyze, and Learn From Diagnostic Safety Events. July 2022. 22-0038. Updated March 2024. Accessed September 4, 2025. https://www.ahrq.gov/diagnostic-safety/tools/measure-dx.html.

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approach to care that is driven by the implementation and adherence to the proper structures and processes. The additional focus on key structures and processes can provide the resources necessary to deliver on the optimal care pathway and manage patients when rescue strategies are identified and needed.

ASM Cost Performance Category Considerations

The Acumen methodology used in MIPS is very narrowly defined, limiting its value for incentivizing reduction in cost within MIPS/MVPs. **This is another example where the Agency seeks to define team-based care and its accountability at the individual level. Much of modern care is an orchestration of several role players with a single impact on the patient's outcome. Designing cost accountability at the transaction level of each contributing individual disaggregates the efforts of an efficient care model.**

CMS' MIPS cost measures attempt to constrain charges to what is substantially in the direct influence of a single physician—though, further complicating the issue, there are also concerns that clinicians are attributed to measures that have little influence over care related to the episode. Individual transactions from individual clinicians are combined within an episode of care to create the total cost of care for a patient. The result is a failure to involve the bulk of the care team (e.g., anesthesiology, radiology, pathology, and other medical specialties) in both a quality- and cost-conscious program. **The judgment applied to determine what is in the control of a specific physician is statistically "noisy" at best because care delivery is typically team-based in the modern delivery system.** We see this in the low back pain cohort proposed by the Agency in the ASM. **The spotty cost coverage of a few common procedures as a transaction does little to promote a surgeon's or a team's attentiveness to cost. Moreover, the current provider-centric approach to episode construction is conceptually out of step with industry standards. It is simply not consistent with a patient-centered framework for measuring and improving the value of care.** In addition, the process of developing these measures has been costly and time-consuming, with fewer than 35 measures developed and implemented in the 10 years since the passage of the Medicare and CHIP Reauthorization Act (MACRA). The result is huge gaps in the availability of measures that reflect the cost of care for some patients or the work of certain specialties. A more accurate approach to consider is leveraging cost, or price, for clinical services built on a group of related services which, to a patient, comprise the collection of services for their particular condition or procedure. A more detailed description of an alternative approach is included below.

The Alternative: A Team-based, Inclusive Methodology

CMS should consider converting to a methodology similar to that used in the Episode Grouper for Medicare (EGM)[23]. The EGM offers a more complete taxonomy of all diagnosis and procedure codes and currently contains over 120 fully specified episodes and several hundred other episodes drafted preliminarily and ready to serve as an "assembly line" for vetting and refinement. EGM-based episodes are patient-centered rather than specialty specific, meaning that they are more reflective of the overall cost of care that a patient or their payer would experience for the treatment of a given condition. Given the robust base of defined episodes, using such an approach could multiply the set of available measures within months and continue high-output production for the next several years, rapidly filling in the gaps preventing widespread adoption of meaningful MVPs (or APMs). **The EGM methodology recognizes interrelationships between concurrent or overlapping episodes of care**

[23] Centers for Medicare & Medicaid Services. Method A: Episode Group for Medicare (EGM) Design Report. February 29, 2016. Accessed September 11, 2025. https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/macra-mips-and-apms/egm-design-report.pdf.

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and by doing so avoids double counting resources (appropriate price accountability). A CMS Innovation Center model is the ideal testing ground for this approach.

An advantage to cost measures based on this methodology is that it includes a wider range of condition episodes that provide infrastructure for assessing non-procedural work for conditions for which surgery may be indicated but is not always the optimal treatment. As an example, consider osteoarthritis as a condition episode, which might include nested procedural episodes for total joint replacement of the hip or knee. **Rewarding clinical teams for making appropriate decisions with their patients to utilize physical therapy, injection therapy and other options to avoid or delay joint replacement would help to correct incentives but requires the use of an episode logic for price modeling which considers all these elements of costs concurrently.**

Team-based cost measures derived from claims data may also be accessible as a proxy for quality indicators to signal if performance that otherwise seems to pass as excellent might be more correctly described as merely acceptable or even unacceptable. In other words, the claims-based measures could serve as a backstop against significantly abnormal rates of adverse events, which might not be so easily detectable without careful articulation of the episode framework and episode definitions. These measures do not replace what is needed for "quality as a program,"[24] which requires formative measures related to verification and patient-reported outcomes to ensure or stimulate improvement and excellence.

Ideally, the Agency should measure cost as a component of the quality program. By aligning quality and cost measures across the same episode of care, as it is experienced by the patient, CMS would provide patients with an expression of value for the condition under consideration. That is, patients and their referring physicians would be presented with a more comprehensive and meaningful representation of the cost and quality outcomes experienced by similar patients for the same care.

As previously noted, the ACS opposes implementation of the ASM as proposed and urges the Agency to pause the model to allow for the Agency to consult with relevant specialty societies and stakeholders to create an alternative that would be more meaningful to physicians and patients. However, if CMS does decide to move forward with the model as proposed, it would seem prudent at a minimum for the Agency to embrace pilot testing of alternative, potentially superior software and clinical episode definitions in order to vet the prospects of implementing measures which better inform team-based care and patient-centered value. The ability of the EGM to function at multiple sub-Taxpayer Identification Number (TIN) levels readily allows for "cutting" performance feedback reports to reflect sub-TIN cost, preoperative costs, intra-facility costs, and post-discharge costs for a large number of conditions and procedures. This would make possible more meaningful quality/price notation for a payment program structured around MVPs.

We would be interested in partnering with CMS and CMS Innovation Center to model this work.

Putting it All Together in A New Value-Based Care Framework

How to align quality and cost measures over the same episode of care while incentivizing "systemness" to measure the structure, process and the resiliency of team across episode, and ensuring patient-centricity? The ACS proposes the below quality framework as a solution that views "quality as a program" of care:

[24] Peters X, Sage J, Collins C, Opelka F, Ko C. Programmatic quality measures: a new model to promote surgical quality. *Health Aff Sch*. 2024;2(1):qxad094.

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1. **Patient Goals of Care.** *What is the goal of the patient's care? Was the goal achieved, according to the patient and/or caregiver?*
    - The Agency should refocus care on the patient by using metrics that center on results that matter to patients. This will help patients and referring doctors determine the quality of care being provided by the care team in a specific setting, such as shared decision making (SDM), patient goal attainment, and other patient-reported outcomes. For example, in the low back pain cohort, the outcome that matters to the patient might be whether their backpain went away. To fill this gap, the ACS recently submitted a measure, the CollaboRATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients, that was developed to assess the quality of patient SDM for surgery in the ambulatory setting to improve patient-centricity, patient outcomes, and unnecessary care. This measure was submitted due to the lack of metrics in CMS programs that focus on patient preferences or the appropriateness of surgical decisions. We strongly recommend the CollaboRATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients measure, and similar measures should be a top priority to assess and promote alignment between an individualized decision to operate and patient goals.

2. **Risk-adjusted Cost at Episode Level, Including the Facility if Applicable.** *Who are the high-risk patients and how much do they cost? What are the services you are assigning to the condition? Are services aggregated around the primary episode to define the whole care journey?*
    - While the ASM as proposed is focused on the individual physician, the ACS believes that to be meaningful in terms of providing actionable information for care decisions and quality improvement the Agency should instead consider a model built around a more comprehensive episode that includes costs related to facilities (if applicable). Starting from a more inclusive perspective is reflective of care experienced by the patient and creates better alignment with the optimal unit of analysis for quality.

      To achieve this, we recommend reporting cost variables around total cost for the episode. The total cost can be subdivided into cost without major complications and cost with major complications. We also recommend cost be risk-adjusted (for example, using hierarchical condition category (HCC) adjustments) using the observed to expected ratio (O/E), then report the total complications with the list of major complications as a side bar so the institution can see where they should put their efforts to avoid major, rare but costly harms. There are too many minor complications to evaluate them separately—to address minor complications (the harms due to a thousand small cuts), systems verification brings forward the focus on improving process, structure, and workflow. This information can then be used by Accountable Care Organizations (ACOs) and PCPs as they make referrals.

3. **Track Major Adverse Event (AE) Avoidance** (not individual AEs)**.** *Has the care team avoided all major complications for the condition?*
    - AEs are nearly impossible to measure on the individual level due to "low numbers." Because of low incidence there is limited value in measuring AEs in isolation, especially in the ambulatory setting. **An alternative to consider is whether the care team avoided all major complications. This can be done by aggregating quality in two ways: all potential complications (major and minor) at a rate in each risk group. The key**

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metric is the percentage of cases with zero major complications. Here is an example for low back pain:

Low Back Pain	Volume	$ in O/E (HCC adjusted)	Mean Risk Score (HCC)	Zero Major Complications	Total Complications
Team A	30	1.2	0.9	92%	18%
Team B	55	0.99	1.5	98%	8%

- Team A does approximately half the number of episodes as compared to Team B, but their cost is higher than expected in a low-risk population. They also have higher rates of major complications and a moderate-to-high total complication rate.
- Team B hits their mark for expected costs despite a high-risk population and has excellent avoidance of major and total complications.

4. **Verification of Care for the Condition.** *Does the team have the right structures and processes in place to avoid minor and major complications? Do they have the ability to rescue?*
    - The ASM as proposed will cover services which may or may not include inpatient or other facility-based care. In cases where the condition episode includes facility-based procedures, a high-performing care team works within a system that has the right structures and processes in place to deliver on the optimal care pathway AND manage patients when rescue strategies are identified and needed. It is more than doing the routine steps; rather, it is the little details together that take care from good to great. The current payer measurement systems do not have this capability. The ACS has years of experience developing and implementing quality programs in our ACS verification and accreditation programs. These programs are intended to complement payer measures, while also assessing the interconnectedness of a team in a service line. They assess a care team's capacity to identify problems, use clinical measures, formulate improvement plans, execute a work plan, and seek solutions, all as a learning health system. Most health systems do not harbor mature systems approaches to their service lines; therefore, it is important that CMS consider how to leverage programs, such as the ACS verification and accreditation programs (such as ACS Geriatric Surgery Verification, Trauma, Bariatric Surgery, and Cancer) and similar programs that have proven success in implementing systems, to support the Agency's efforts to help patients and support care teams.

As noted previously, the ACS, working with the team at the Brandeis University, developed the Episode Grouper for Medicare and proposed an episode-based APM that would have facilitated chronic care episodes with nested procedural episodes. While this model was not ultimately implemented, it was recommended by the PTAC for testing. In the years since the development of this model, the ACS **has continued to develop our thinking on how to best measure quality and cost across an entire episode in a way best suited to incentivize care improvement and cost reduction. We welcome the opportunity to discuss collaboration with CMS to make such a model a reality.**

The below comments are in response to specific ASM proposals.

Proposed Mandatory Participation

CMS proposes that participation in the ASM would be mandatory for all clinicians who meet participant eligibility criteria, explaining that this is needed to eliminate selection bias and to ensure sufficient

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volume to yield generalizable results. The Agency also proposes that once a clinician meets the eligibility criteria, they would be considered an ASM participant for ***the duration of the model***. These clinicians would be exempt from MIPS reporting for any ASM performance year that they meet the ASM participant eligibility criteria and model requirements. But then CMS discusses how eligibility would be reassessed each performance year and that if the participant doesn't meet eligibility criteria for the upcoming ASM performance or payment year, the ASM participant would have to participate in MIPS.

First, it is our understanding that for any model year that the participant does not meet the ASM participant eligibility criteria for the upcoming ASM performance or payment year, the ASM participant would not be required to submit data in accordance with the model, nor would they receive an ASM payment adjustment. In this case, the ASM participant would no longer be exempt from MIPS and would be required to satisfy any MIPS reporting obligations and would receive a MIPS payment adjustment two years later. However, as stated, the Agency also proposes that once a clinician meets the eligibility criteria, they would be considered an ASM participant for ***the duration of the model***. **These two policies seem to contradict themselves and we seek clarity from CMS on what this will look like for ASM participants.**

This proposed policy also requires clinicians who are Qualifying APM Participants (QPs) in Advanced APMs to also report under the ASM if they meet the ASM eligibility criteria. This is concerning because clinicians who are currently exempt from MIPS will now be required to individually report MIPS quality and cost measures. This would also include clinicians who are currently exempt from MIPS because they do not meet the volume thresholds to participate.

CMS also states that the ASM will not qualify as an Advanced APM. **This moves further away from the Agency's goal to transition away from traditional MIPS** and would ultimately be a step backward in efforts to incentivize participation in innovative value-based care models by requiring clinicians to participate in individual-level MIPS-like reporting.

To this end, the ACS does not support the mandatory nature of this model. Additionally, it is burdensome and redundant to require clinicians who are exempt from MIPS or who are QPs under an Advanced APM to also participate in the ASM. If the mandatory nature is finalized, we recommend that clinicians currently participating in Advanced APMs or those who are exempt from MIPS based on other eligibility criteria be exempt from the ASM.

ASM Low Back Pain Cohort

For the ASM Low Back Pain (LBP) cohort, CMS proposes to include the following specialty types:

- Anesthesiology,
- Interventional pain management,
- Neurosurgery,
- Orthopedic surgery,
- Pain management, and
- Physical medicine and rehabilitation

In the proposed rule, the Agency discusses its decision to include both nonsurgical and surgical specialties in the cohort. While we generally support the concept of shared accountability to incentivize team-based care in an episode, the model does not foster team-based management of a patient's care over the trajectory of a condition like LBP.

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As proposed, it appears that both the cost and quality components lack relevance and applicability to many members of the clinical team taking care of patients with LBP. The quality measures included in the model are not reflective of the care delivered by some specialists who are selected for ASM participation, especially surgical specialties. For example, neurosurgeons can be included in the ASM cohort, however, none of the measures proposed to be included in this model are in the MIPS Neurosurgery Specialty Set. In fact, the Functional Status Change for Patients with Low Back Impairments measure was developed by physical therapists and includes physical therapy, chiropractic, nursing facility, and E/M codes. We also seek clarity on which providers are intended to report the MRI Lumbar Spine for LBP measure since it's still under development.

Furthermore, the model is likely to pull in specialists who see a low volume of patients with LBP. This is reinforced by CMS' statements that "mandatory participation is necessary to ensure sufficient volume to yield generalizable results," yet the Agency discusses in the rule how over one-third of the specialists required to participate would only have 20-29 attributed episodes under the Low Back Pain Episode-Based Cost Measure. This has potential to negatively skew cost performance due to low case volumes and hold specialists accountable for care that is not their primary area of focus.

The LBP cohort illustrates many of the issues we raise in our overview detailing flaws in the ASM. Instead of narrowly defining this condition using the convenient measures CMS has proposed, the model should aim to transparently understand the cost of managing an LBP patient and include both primary care and specialists, including post-acute care (PAC) providers, and evaluate quality for the entire care journey—not just select clinician types contributing to very specific portions of that care. To do this successfully, the Agency should be asking—what are all the services included in an LBP episode? Which quality measures will demonstrate the care team delivered on patient goals? Has the care team avoided all major complications for the condition? Are services aggregated around the primary episode to define the whole care journey? Does the team and facility (if applicable) have the right structures and processes in place to avoid minor and major complications? Do they have the ability to rescue? And so on.

UPDATES TO THE QUALITY PAYMENT PROGRAM

CY 2026 Modifications to the Quality Payment Program Reporting and Data Submission

Maintaining the MVP Group Reporting Option for Small Practices

To help address small practice challenges, CMS proposes to modify the definition of an MVP participant to mean an individual MIPS-eligible clinician, single specialty group, multispecialty group that meets the requirements of a small practice, subgroup, or APM Entity that is assessed on an MVP for all MIPS performance categories. If finalized, this policy would allow multispecialty small practices to report as one, instead of needing to divide into subgroups. **The ACS supports this proposal because it reduces the quality reporting burden on small practices.** This proposal will allow small practices the flexibility to determine the MVP that best suits their practice. It also removes requirements that could force small practices to unnecessarily report multiple MVPs or MVPs that may be new to them which would significantly increase burden on practices that can have less available resources.

Proposal to Modify the MVP Group Registration Process

CMS previously finalized the definition of a single specialty group as a group consisting of one specialty type and the definition of a multispecialty group as a group consisting of two or more specialty types, as determined by the Agency using Medicare Part B claims. To implement the CY 2026 subgroup reporting requirement for multispecialty group practices, CMS considered utilizing claims data to assign

specialty designations to group practices. The Agency acknowledges various situations where claims may fall short in showing how a practice functions. In lieu of using the claims data for designating a group as either a single specialty or a multispecialty group, CMS proposes that, beginning with the CY 2026 performance period/2028 MIPS payment year, a group practice registering for MVP reporting that intends to participate as a single group would need to attest either as a single specialty group or a multispecialty group that meets the requirements of a small practice during MVP registration.

To align with the proposed self-attestation process during MVP registration as a mechanism for identifying the group specialty composition, the Agency also proposes to modify the definition of a single specialty group to mean a group that consists of clinicians in one specialty type or clinicians involved in a single focus of care and to revise the definition of a multispecialty group to mean a group that consists of clinicians in two or more specialty types or clinicians involved in multiple foci of care.

The ACS thanks CMS for acknowledging stakeholder feedback regarding the shortfalls of claims data to designate subgroups within multispecialty groups. We support the Agency's proposal to revise the definition of multispecialty groups and allow groups to designate the specialty composition of their group. This will allow practices to better align MVP reporting with their practice.

However, we request that CMS make the following small modifications to its proposed definitions to more accurately capture what we believe is the Agency's intent under this proposal and to ensure the definitions are mutually exclusive:

- Multispecialty group means a group as defined at § 414.1305 that consists of clinicians in two or more specialty types NOT involved in a single focus of care or clinicians in two or more specialty types involved in multiple foci of care.
- Single specialty group means a group that consists of one specialty type or consists of clinicians in two or more specialties involved in a single focus of care.

Core Elements Request for Information

Current MVPs contain an average of 14 quality measures for MVP Participants to select from, ranging from 8 to 24 quality measures in each MVP. Because of this, CMS is considering policies to ensure more direct comparability by requiring the reporting of a subset of measures within an MVP that are meaningful for clinicians and patients. Specifically, the Agency is considering a policy to require an MVP Participant to select one quality measure from a subset of quality measures in each MVP, referred to as "Core Elements." CMS is considering the Core Elements policy for the CY 2027 MPFS proposed rule prior to the sunsetting of traditional MIPS. When new MVPs are proposed, the Agency would identify the MVP's Core Elements at that time through notice and comment rulemaking. Given the existing quality measure gaps for certain specialists and subspecialists, there may be clinicians for whom there would not be an applicable and available Core Element.

The ACS does not support the general concept of Core Elements without further understanding which specific types of measures would be used. We understand CMS' intent; however, it is a false assumption that a quality measure within an MVP would apply to all participants, especially in MVPs that are broadly defined. MIPS-eligible participants represent a diverse group of healthcare professionals who focus on specific clinical areas within extremely diverse patient populations.

Selecting core measures for MVPs that are extremely broad, such as the Surgical Care MVP, will be particularly challenging. One might assume that measures, such as surgical site infection (SSI) or reoperation, would apply across the MVP and can be compared across different data sources, but this is

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not the case. [25] For example, the SSI MIPS measure is not specific enough to evaluate SSI across all surgical procedures in its specification—and even if it was, adverse events like SSI will not achieve statistical power due to low case volume when measured on the individual level.[26] Instead, this measure should be procedure-specific to capture the nuances and variability across each surgical procedure and should be aggregated to the facility level to increase case numbers. This demonstrates how even within a clinical domain, quality is not one-size-fits-all. This MVP focuses broadly on surgical care, grouping together numerous surgical specialties that do not perform the same procedures and practices can greatly differ. Adding Core Elements to this MVP will result in more unnecessary reporting burden, data that do not represent the most important aspects of surgical care, and data that are of little value to the patient and impacted clinicians.

One exception to be considered for Core Elements are patient-reported outcome measures (PROMs) for the MVP condition that assess what matters to the patient. PROMs which assess key outcomes of the condition, such as patient goal attainment, could be considered for Core Element measures. When you think about surgical care, tracking adverse events is important, but it only affects a limited number of patients. On the other hand, patient-reported outcomes (PROs) assess every surgical patient and offer opportunities for patients to express their experience, satisfaction, level of goal attainment and so forth. Where few other measures help to inform referring physicians and patients, PROs fill a gap.

For surgical patients, relevant categories of PROs/PROMs are outlined in Table 2.

TABLE 2. PRO/PROM Categories

Functional Outcomes	• Physical function (e.g., mobility, strength, range of motion) • Activities of Daily Living (ADLs) • Return to work or normal activities • Sports and exercise capacity (for relevant surgeries)
Pain and Discomfort	• Pain intensity scales (e.g., Numeric Rating Scale, Visual Analog Scale)[27] • Pain interference with daily activities
Quality of Life	• General health-related quality of life (e.g., SF-36,[28] EQ-5D[29]) • Disease-specific quality of life measures
Mental Health and Well-Being	• Anxiety and depression scales (e.g., HADS,[30] PHQ-9[31]) • Emotional well-being • Social functioning

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Symptom Burden	• Fatigue • Sleep disturbances • Gastrointestinal symptoms (for relevant surgeries)
Patient Satisfaction	• Satisfaction with surgical outcomes • Satisfaction with care process • Willingness to recommend the procedure/provider
Recovery and Rehabilitation	• Progress in rehabilitation • Adherence to postoperative instructions • Complications or adverse events from the patient's perspective

For a comprehensive approach to PROs/PROMs in surgery, consider the following categories:

1) **Generic Health Status:**
   Use widely validated tools like SF-36 or EQ-5D to assess overall health status and quality of life. These allow for comparisons across different surgical procedures and patient populations.

2) **Procedure-Specific Measures:**
   Implement measures tailored to specific surgical procedures. For example:
   - Oxford Hip Score for hip replacements[32]
   - BREAST-Q for breast surgery[33]
   - International Prostate Symptom Score (IPSS) for prostate surgery[34]

3) **Functional Status:**
   Assess physical function relevant to the specific surgery. This could include measures of mobility, strength, or specific functional indices like the Oswestry Disability Index for spine surgery[35].

4) **Symptom Assessment:**
   Focus on symptoms most relevant to the surgical procedure, such as pain, fatigue, or procedure-specific symptoms.

5) **Psychosocial Outcomes:**
   Include measures of mental health, social functioning, and overall well-being to capture the broader impact of surgery on patients' lives.

6) **Recovery Trajectory:**
   Implement measures that track patients' recovery over time, assessing milestones like return to work or normal activities.

7) **Patient Experience:**
   While not strictly a clinical outcome, patient experience measures can provide valuable insights into the care process and may influence overall outcomes.

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8) **Goal Attainment:**
Consider using patient-specific goal attainment scaling to assess whether individual patient goals for surgery were met.

Considering well-designed set of PROs/PROMs for Core Elements of MVPs will provide surgical teams with a more comprehensive understanding of surgical outcomes from the patient's perspective and provide information for referring physicians and patients seeking care.

Medicare Procedural Codes Request for Information (RFI)

The Agency is considering a potential future policy to require clinicians to report a specific MVP based on the procedural codes they bill. Within this RFI, the Agency asks various questions about how this could be operationalized. It is important to note that in the current program MVP participants may select any MVP they wish to report.

While the ACS agrees with CMS that it is important that clinicians are evaluated on quality measures most relevant to the care they deliver, we are concerned that the use of procedural codes in claims data will not accurately depict a physician's role in the episode of care. For example, earlier in this proposed rule, the Agency discusses how claims data does not always reflect the nuances of how a care team works together to deliver on an episode of care.[36] In addition, there are some instances, such as when a practice utilizes Advanced Practice Providers (APPs), where a visit or procedure is attributed to a physician but is being delivered by the APP that works as part of their practice. When claims are used to attribute specialists, especially surgeons, to procedures or episodes of care, this has shown to be a major contributor to inaccurate attribution of physicians. Another concern is this policy contradicts earlier policies being proposed in this rule that allows more flexibility for multispecialty groups to determine the MVP participation designation that best represents them. The ACS asserts that clinicians are best suited to identify the focus of their practice, their relationships with their patients, and the measures that best align with the care they deliver.

Quality Reporting and Data Submission

Development of New MIPS Value Pathways (MVPs)

CMS proposes to adopt six new MVPs, including a Vascular Surgery MVP. **The ACS appreciates CMS and the Society of Vascular Surgery's (SVS) work to develop this MVP. The ACS supports collaborative efforts between the Agency and surgical societies to create frameworks to improve quality across surgical care.** The Vascular Surgery MVP is a step in the right direction towards creating a quality reporting pathway that supports the work of vascular surgeons. As CMS continues to develop and maintain MVPs, we want to alert the Agency of the ACS' & SVS Vascular Surgery Verification program as a model for quality improvement in this surgical service line. The Vascular Surgery Verification was developed through collaborative efforts by the ACS and SVS to deliver a quality verification program focused on the care and treatment of patients receiving vascular surgical and interventional care in an inpatient setting. This program provides an evidence-driven, standardized pathway for establishing and growing the quality improvement and clinical care infrastructure within a vascular program.[37] This program follows the same structure as other ACS accreditation and verification programs that set standard practices to align structural and process elements to improve patient outcomes and optimize the work of the care team. **As CMS continues to build out MVPs in surgical**

[36] 90 FR 32352
[37] Vascular Verification Program. American College of Surgeons. Accessed August 26, 2026. https://www.facs.org/quality-programs/accreditation-and-verification/vascular-verification/

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care, we recommend the Agency consider leveraging frameworks such as the Vascular Surgery Verification that helps care teams create standard practices to avoid major complications, implement the right processes and structures to avoid minor complication across a facility, and puts the team in a position to meet patient goals.

Toward Digital Quality Measurement in CMS Quality Programs RFI

CMS states its intent to transition to a fully digital quality measure (dQM) landscape; therefore, the Agency is asking for feedback on its anticipated approach to the use of Health Level Seven (HL7) Fast Healthcare Interoperability Resources (FHIR) in electronic clinical quality measure (eCQM) reporting across CMS programs. CMS also describes its efforts to collaborate with other agencies such as the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator (ONC), the Centers for Disease Control (CDC), and others to support data standardization and alignment of requirements for the development and reporting of digital quality measures.

The ACS appreciates the opportunity to provide feedback on this important issue. To start, it is important to highlight the progress that has been made through the implementation of various elements of the 21st Century Cures Act through the Cures Rules and other regulations in recent years. CMS' goals expressed in this RFI to leverage FHIR and standards to support quality measures will be beneficial to supporting the future of digital quality measurement. This shift is logical for measures that demonstrably improve patient outcomes or care quality. Automating the generation of such measures can free up clinical resources and improve data accuracy.

Considering the rapid transformations across the digital healthcare ecosystem, it is important that the Agency identify where investments in technology will be most impactful. This RFI solely focuses on steps to transition to electronic clinical quality measures (eCQMs); however, we are concerned that only focusing on eCQMs without working towards integration of more advanced technology to aggregate quality measures will not keep pace with the needs of the healthcare delivery system. **Instead, we recommend CMS explore ways to create a glidepath to digital quality measures that acknowledge the important clinical data within the electronic health record (EHR), but also can leverage advanced technologies, such as AI-enabled large language models (LLMs) to gather additional context from unstructured data within clinical data sources.** Structured, standardized clinical data in the EHR should be considered ground truth, but additional information can be learned about a patient's care journey and the relationship between the physician and the patient from additional data sources. The ability to leverage both structured and unstructured, standardized clinical data from various data clinical data sources will allow for more innovative quality measurement solutions in the future.

It is also important to caution that moving to digital measures may simply make it easier to report on the wrong things—including metrics that lack clinical, procedural, or patient-centered value—such as those that focus narrowly on provider or facility characteristics without reflecting meaningful aspects of surgical episodes or patient outcomes. If these measures are not critically evaluated for relevance, digitization could perpetuate the collection of low-value data rather than addressing the core issue: the need to retire or redesign measures that do not drive improvements in care. The Agency must also be open to the implementation of new innovative measures that reflect the diversity of medicine to ensure physicians can meaningfully show the quality of care they provide. **Instead of just digitizing existing measures, CMS should prioritize:**

- **Reviewing existing measures for clinical relevance and patient centricity;**
- **Retiring or revising those that do not meaningfully reflect quality or outcomes; and**

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- **Replacing existing measures with new digital measures that align with the realities of clinical practice and patient needs, including team-based, patient-centered care, and are not hampered by the limitations of specific payment systems.**

If this is accomplished, the ACS sees great potential in leveraging technology to support quality programs and quality improvement.

MIPS Performance Category Measures and Activities

MIPS Quality Performance Category

High Priority Measure Definition

CMS proposes to amend the definition of the term high priority measure to mean an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure beginning with the CY 2026 performance period/CY 2028 MIPS payment year. This would result in the removal of quality measures pertaining to health equity in the definition of high priority measure, an addition finalized the 2023 MPFS final rule during the PHE for COVID-19.

Given the proposed removal of health equity quality measures from the high priority definition, the ACS would like to highlight the importance of environmental and social factors when considering the health of the whole patient. Looking at all relevant factors—procedural risk, condition risk, and social determinants—that contribute to the patient's success before, during, and after an operation is essential.

Selection of Quality Measures

Inventory of Quality Measures

CMS proposes the addition, removal, and updates to numerous MIPS quality measures. The ACS highlights the limitations of the MIPS quality measures and MVP framework for surgical care, including:

- MVPs include broad measures that lump many different procedures into a measure or set of measures, such as the Surgical Care MVP which defines surgeons in general terms;
- Often the measures selected for inclusion focus on rare adverse events;
- Reporting on the individual clinician results in small case numbers which are inadequate to demonstrate precision or meaningful confidence intervals—this is especially challenging with rare events/adverse events;
- The unit of measurement in MIPS is the individual clinician which does not create incentives for team-based care—instead, it pits care team members against each other;
- Limited availability of PROs and PROMs in surgical care that focus on what matters to the patient; and
- Lacks ability to assist patients in making informed decisions about their care; this extends to patient advocates, PCPs, or purchasers seeking to make referrals.

These issues are compounded by the payer/purchaser approach to using the FFS payment system that ties payment to individual clinician performance on measures without considering a method that accounts for shared accountability. Performance data end up being too general to be useful, or else too specific to meet statistical thresholds for accuracy and reliability, which results in data that are not useful

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for clinician self-improvement, referral decisions, or patient decision-making. A one-size-fits-all approach to measurement may seem prudent and easier to implement in a payment model; however, surgical services are too diverse for a one-size-fits-all approach if it is to be informative and meet the needs of the various stakeholders.

The practice of medicine and the environment in which care is provided are extremely nuanced. Relying on measures in their current state to capture a care team's ability to manage patients will not achieve the Agency's goals of driving value. From our experience, the fix must start with the QPP refocusing on the patient. The current system focuses more on the work of the individual clinician, instead of the patient's experience and how the team functions to deliver good care to a patient. To refocus on the patient, CMS must look to measure the patient with a certain condition within an episode attached to the facility, rather than the individual clinician. Only focusing on an individual clinician further fragments care without holding the team accountable for how it works together to deliver the best care to its patients. By defining episodes that are inclusive, yet targeted, that also create shared accountability across the care team, the Agency can build shared incentives and coordination across the delivery system.

In the ACS' years of experience developing and implementing quality programs in verification and accreditation programs we have demonstrated the importance of developing systems that support an interconnected team in a service line. Verification and Accreditation programs assess a care team's capacity to identify problems, use clinical measures, formulate improvement plans, execute a work plan, and seek solutions, all as a learning health system. Because most health systems do not harbor mature systems approaches within their service lines, it is important that CMS consider how to leverage programs that have proven success in implementing systems to support the Agency's efforts to help patients and care team.

The ACS has developed programmatic measures that build on this concept, most notably the Age Friendly Hospital measure,[38] which is now reported in the Hospital Inpatient Quality Reporting Program (IQR), to center quality around a patient and bring the care team together around patient goals. Measures that follow a quality program, referred to as "programmatic measures," identify clinical frameworks based on evidence-based best practices to provide goal-centered, clinically effective care for patients.

The concept behind the programmatic measure is based on several decades of history implementing programs that demonstrably improve patient care provided by both the clinical team and the facility. Examples include ACS Trauma programs, Geriatric Surgery Verification, Bariatric Surgery Accreditation, ACS Cancer program, and more. Programmatic quality measures 1) align multiple structure, process, and outcome measures; 2) target condition- or population-specific care; 3) apply to multiple quality domains; 4) address the continuum of care; and 5) are informative to and actionable for care teams and patients. The integration of structures, processes, and outcomes for common clinical purposes is fundamental to programmatic measures and follows the Donabedian framework.

Based on our experience, programmatic measures demonstrate applicability to diverse care settings, limited burden on care providers, and demonstrably better results. Applied correctly, programmatic measures will address the quality gaps created by the current measures, such as MIPS/MVPs. Programmatic measures have benefits across stakeholders:

- **Patients:** Widespread implementation of these measures would benefit patients and caregivers by increasing transparency and empowering them to make effective decisions about where to receive care.

[38] John A. Hartford Foundation. CMS Approves New 2025 Age-Friendly Hospital Measure. August 1, 2024. Accessed September 11, 2025. https://www.johnahartford.org/resources/view/cms-passes-new-2025-age-friendly-hospital-measure.

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- **Clinicians:** The clinical team would benefit from integration into a commonly shared goal by defining and operationalizing a clinical unit-based system.
- **Systems:** Healthcare systems would benefit from resource and protocol standardization, evidence-based and data-driven processes, and pragmatically functional strategies to achieve improved care and outcomes.
- **Payers:** Payers would benefit by taking a programmatic quality approach because they can be confident that their beneficiaries will receive high-quality care with efficient cost savings.

In summary, the Agency must continue to explore ways to align programs that are built to bring care teams together around the patient, such as episode-based payment models and programmatic measures in CMS programs such as the Age Friendly Hospital measure. These efforts are taking steps to move the system closer to value-based, team-based care that provides meaningful information to patients, physicians, and other stakeholders, while MVPs and traditional MIPS are splitting teams into individual members and distracting from the Agency's goals.

Cost Performance Category

Inventory of Cost Measures

Total Per Capita Cost (TPCC) Measure

CMS is proposing the following substantive changes to the Total Per Capita Cost (TPCC) measure.

1) Require that both services in a candidate event are provided by the same clinician group and by a clinician with a specialty included in measure attribution. This modification would result in MIPS-eligible clinicians only being attributed the costs of care for beneficiaries that have had at least two qualifying services from their clinician group, and where both services were provided by a clinician that would not be excluded from measure attribution due to the specialty exclusion.
2) Modify the TPCC measure's specifications to exclude certain clinicians and clinician groups from attribution, such as advanced care practitioners who work within a specialty practice. Advanced care practitioners, even while working within a specialty practice, often provide primary care and ongoing care management services. In these instances, an advanced care practitioner may bill services (such as office visits) to support specialized care that are unlikely to be indicative of primary care or ongoing care management relationships. This proposed modification would limit instances in which the TPCC measure would be used to assess or evaluate costs potentially associated with highly specialized clinician groups due to the billing patterns of advanced care practitioners within the clinician group.

The ACS thanks CMS for proposing this new attribution methodology; however, we are concerned that the policy will still not attribute clinicians in the way the measure is intended. As stated, it is common for specialists, including surgeons, to be scored on this measure when it is not intended to evaluate specialty care. From our perspective, the second exclusion criteria that only excludes advanced care practitioners (ACPs) from attribution in situations where 100 percent of physicians in a group are excluded based on the specialty exclusion criteria is inadequate. When you consider the makeup of specialty groups, they can consist of many different provider types, not just specialists and ACPs, which has potential to still attribute all members of the group to this measure.

In addition, based on analysis of the 2023 QPP public use file, we found that of the 5,691 general surgeons who received a MIPS cost category score, 87 percent were receiving cost scores based on the TPCC measure with the average scores around 5.1 points. This trend of high surgeon attribution and scoring and low TPCC scores is seen across a number of surgical specialties, displaying that while this

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measure is not intended for surgeons they are being attributed and scored on this measure at a very high rate. This is further demonstrated in Table 3 below.

TABLE 3. TPCC Scores by Specialty

Specialty	Total MIPS-Eligible Clinicians	Cost Performance Category (1)			% of MIPS-Eligible Clinicians Attributed to TPCC Measure	% of Clinicians with Cost Category Score Attributed to TPCC Measure
		Total MIPS-Eligible Clinicians Receiving Cost Category Score	Total Clinicians Attributed to TPCC Measure	Average TPCC Score		
General Surgery	**10,558**	**5,691**	**4,967**	**5.1**	**47%**	**87%**
Anesthesiology	17,575	9,402	8,051	4.5	46%	86%
Cardiac Surgery	622	321	274	5.2	44%	85%
Colorectal Surgery (formerly Proctology)	920	505	412	5.1	45%	82%
Hand Surgery	1,058	449	407	4.4	38%	91%
Maxillofacial Surgery	240	120	118	4.9	49%	98%
Neurosurgery	2,911	1,589	1,403	4.6	48%	88%
Ophthalmology	13,739	7,733	1,708	4.7	12%	22%
Orthopedic Surgery	13,482	7,092	5,699	4.5	42%	80%
Otolaryngology	5,635	2,135	2,069	5.2	37%	97%
Plastic and Reconstructive Surgery	1,669	911	789	4.7	47%	87%
Surgical Oncology	767	360	345	4.5	45%	96%
Thoracic Surgery	1,392	737	663	5.2	48%	90%
Urology	6,113	2,617	2,224	5.0	36%	85%
Vascular Surgery	2,400	1,253	972	5.4	41%	78%

Because performance on cost is heavily weighted in a physician's MIPS total score, this can negatively impact how they perform in MIPS as well as their reimbursement. We ask CMS to consider retroactively applying these updates to the TPCC cost measure so they would apply to the 2025 performance year/2027 payment year. Because these data are still being reported and scores have not been finalized, it should be feasible to apply these changes to the data for the 2025 performance period. The Agency has done this in the past, with updates to the cost category effective with the 2024 performance year, as well as through a proposal in this rule regarding the benchmark methodology for scoring administrative claims-based quality measures.

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

CMS proposes that, beginning with the CY 2026 performance period, for the first two years after new cost measures are finalized it would score them for information only purposes. This means that a measure being scored for informational-only scores would not be incorporated into MIPS-eligible clinicians' cost performance category scores or MIPS final scores. The Agency states that if a MIPS-eligible clinician is attributed a cost measure during its informational-only feedback period, it would calculate a measure score and confidentially provide the score, as well as MIPS performance feedback, to the clinician on an annual basis. **The ACS supports this proposal. It is important for MIPS-eligible clinicians to have time to understand how they might perform on new cost measures and what they can expect as benchmarks are defined. It is also important for CMS to gather data on the measures and evaluate the efficacy of new cost measures before they are used to influence reimbursement.** Allowing measures to be used for informational-only purposes for two performance periods will give physicians and the Agency time to prepare for full reporting as well as time to identify any issues with measures that need to be resolved before implementation.

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RFI Regarding Data Quality

CMS explains that as the prevalence of electronic health information continues to grow, and as providers and payers continue to move to a value-based care model, the need for high quality data will become increasingly important. For example, timely, complete data are needed for monitoring adverse events such as antimicrobial resistance. When providers send accurate data the first time, this reduces the need for prolonged testing and email exchanges between providers, public health agencies, payers, and patients. The Agency seeks public comment on challenges around data quality to best ensure data are usable, complete, accurate, timely, and consistent.

Rethinking Data Quality in the Context of Clinical Improvement and AI-Enabled Care

The ACS appreciates CMS' focus on improving the quality, completeness, and usability of electronic health information. However, we believe the current framing—centered on data for quality measurement—must evolve to reflect the broader transformation underway in healthcare. Increasingly, clinicians, patients, and technology partners are focused on data for quality of care and continuous improvement, not just retrospective reporting. The existing data architecture has been largely shaped by EHR vendors and CMS' own eCQM and payment requirements, which will not keep pace with the future. These systems are workflow-centric and billing-oriented lacking the flexibility and intelligence needed to support real-time, patient-centered, AI-enabled care.

Practical Recommendations Within the Current CMS Framework

While we recognize that the Agency must operate within its statutory and regulatory boundaries, we offer the following recommendations to improve data quality and usability in the near term:

- **Recognize Specialty Societies as Stewards of High Quality Clinical Data**: The ACS and other specialty societies have decades of experience aggregating, validating, and applying clinical data for improvement. Programs like the ACS NSQIP demonstrate how clinically-rich, risk-adjusted data can drive better outcomes. CMS should formally integrate these registries and standards into its quality programs.
- **Prioritize Clinical Relevance Over Administrative Volume**: The proliferation of low-value data elements—often driven by billing or compliance—obscures the signal clinicians need to inform care delivery. The Agency should work with specialty societies to define core clinical data sets that matter for outcomes and decision-making.
- **Support Interoperability Beyond the EHR:** The ACS commends CMS for its focus on interoperability and urges the Agency to invest in infrastructure that enables data liquidity across platforms, including patient-facing apps, specialty registries, and AI agents. FHIR-based application programming interfaces (APIs) are a start, but the future lies in modular, patient-centered data ecosystems.
- **Align Quality Measures with Clinical Pathways:** Rather than static eCQMs, the Agency should explore dynamic, quality models based on clinical pathways that reflect real-world care trajectories. Specialty societies can help define these pathways and the data needed to support them.
- **Prepare for a Sovereign Data Future**: As patients gain more control over their data, CMS must ensure that quality programs respect data sovereignty, transparency, and explainability—especially in AI-driven environments.

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A Vision for the Future: Patient-Centered Platforms and Ambient Intelligence

As we consider what the future of healthcare technology can be, we use the example of a cancer patient navigating complex, multidisciplinary care. Leveraging platform technologies that rely on numerous sources of healthcare data such as the EHR, Health Information Exchange (HIE), clinical data registries, and other clinical data sources, and patient-reported data can present a full picture of the patient's health journey. Platforms could present a human-readable map of the patient's care pathway, with each clinician—surgeon, oncologist, radiation therapist, and PCP—represented in their own swim lane. An ambient AI agent could then monitor care in real time, checking for conformance to National Comprehensive Cancer Network (NCCN) guidelines, stage-specific therapies, and patient preferences. Similarly, a primary care physician could use this platform to view population-level insights—such as which patients are overdue for cancer screening or immunizations—supported by explainable clinical reasoning that matches physician-level judgment.

The Agency has taken important steps towards interoperability in making data more available. However, there is more to be done to align the vendor data infrastructure with the fast-moving technology industry. As CMS continues to build out its data infrastructure, we recommend that it consider how to best support sovereign patient data, longitudinal care pathways, and AI-driven reasoning.

Advanced APMs

Attribution Eligible Definition

When CMS finalized the definition of "attribution-eligible beneficiary," it aimed to adopt a definition that would allow it to be consistent across contemporaneous Advanced APMs. It chose to refer to E/M services as the primary basis for purposes of attribution-eligibility because many Advanced APMs used E/M claims to attribute beneficiaries to their APM Entity groups. Over time, the Agency has updated the list of services that are considered to be E/M services for the purpose of identifying attribution-eligible beneficiaries. CMS states that in recent years it has developed concerns that the current policy to use E/M services as the default basis for attribution, and to use an alternative approach for Advanced APMs that use a different attribution basis, could result in a complex set of unique attribution approaches for various Advanced APMs. This also causes variability among the ways the Agency defines "attribution eligible" when making qualifying APM participant (QP) determinations, particularly as CMS anticipates that Advanced APMs will continue to evolve and use novel approaches to value-based care that may emphasize a broad range of covered professional services. In addition, the Agency recognizes that PCPs generally furnish a higher proportion of E/M services than specialists for the same beneficiary. The current reliance on E/M services for attribution in its Threshold Score calculations means that primary care practitioners may contribute more significantly to achieving QP status for an APM Entity group. As such, CMS' current policy may have inadvertently encouraged APM Entities to prefer PCPs over specialists in its Participation Lists. Therefore, the Agency proposes to modify the sixth criterion under the definition of "attribution-eligible beneficiary" to include any beneficiary who has received a covered professional service furnished by the eligible clinician (identified by their National Provider Identifier) for whom CMS is making the QP determination, beginning with the 2026 QP performance period.

As stated in our response to the CY 2025 MPFS, the ACS is supportive of broadening the definition of "attribution-eligible beneficiary," as it will allow more specialists (including surgeons) opportunities to qualify as QPs under Advanced APMs. This is a step in the right direction towards increasing specialty involvement; however, it does not address the larger problem, which is the ongoing lack of APMs that are relevant to specialty care. We do not believe that mandatory participation in MVPs is an appropriate solution to fill these gaps. While this proposal is a welcome update, with the Advanced APM incentive

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payments no longer available and eligibility thresholds increasing under statute, many specialists may still not see the benefit of participating in Advanced APMs at this time. To incentivize surgeons to join APMs and to ensure they can invest in the infrastructure needed to support successful participation in an APM, we urge CMS to ask Congress to extend the Advanced APM incentive payment and to freeze QP eligibility thresholds at the previously lower levels. Importantly, we also urge the Agency to work more closely with stakeholders, such as the ACS, to develop and test new models that are relevant to surgical specialists and reflect the patient-centered, team-based care principles outlined in this comment letter.

The ACS appreciates the opportunity to comment on these important issues, and we look forward to continuing dialogue with CMS on our policy priorities. Please contact Vinita Mujumdar, Chief of Regulatory Affairs, at vmujumdar@facs.org or Jill Sage, Chief of Quality Affairs, at jsage@facs.org with questions.

Sincerely,

Patricia L. Turner, MD, MBA, FACS
Executive Director and CEO

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