September 14, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program; and Medicare Prescription Drug Inflation Rebate Program (CMS-1848-P)

Dear Administrator Oz:

On behalf of the over 95,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments on the calendar year (CY) 2027 Medicare Physician Fee Schedule (PFS) proposed rule published in the *Federal Register* on July 16, 2026.

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 PFS, Quality Payment Program (QPP), the Medicare Shared Savings Program (SSP), 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 these initiatives. Our comments below are presented in the order in which they appear in the rule.

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Summary of Key Recommendations

ACS recommendations are summarized here and discussed in greater detail in subsequent sections.

- **Payment adequacy.** Support building an inflationary update into the PFS, comparable to other Medicare payment programs, separate and distinct from quality incentives and budget-neutral Merit-based Incentive Payment System (MIPS) incentives and advance that position through the Centers for Medicare and Medicaid Services' (CMS's) legislative recommendations.

- **Physician work "efficiency adjustment**." Repeal the policy and, at a minimum, do not treat its continued application as evidence that affected surgical services have become more efficient.

- **Practice Expense (PE)**
  - **Indirect PE allocator**. Apply the sum of work Relative Value Units (RVUs) and clinical labor PE RVUs consistently to all services, including 10- and 90-day global services, as RAND evaluated.
  - **Indirect Practice Cost Index (IPCI) removal**. Delay implementation until the Agency has demonstrated that the proposed methodology produces more accurate resource-based relativity rather than assuming that eliminating an older data source necessarily produces a more accurate result.
  - **Facility indirect PE**. Repeal the CY 2026 50 percent facility indirect PE adjustment and consider implementing a Healthcare Common Procedure Coding System (HCPCS) modifier and an additional PE RVU component as discussed below.
  - **PE Transition**. Implement a four-year transition period for any finalized changes to the PE methodology and publish public files showing annual and fully implemented code-level PE RVU changes and specialty-level impact tables for each distinct PE methodology change.

- **Global Surgical Packages**. Support the proposed pause of the 99024 data collection. Do not use the postoperative visit data, or the "purely arithmetic" values in the public use file, to make widespread reductions to 10- and 90-day global surgical services, and do not view conversion to 0-day global periods as a ready alternative.

- **Valuation of specific codes**. Finalize the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)-recommended values and direct PE inputs for the diaphragmatic hernia repair, congenital duodenal obstruction repair, pancreatic irreversible electroporation, median arcuate ligament, and diaphragm repair families. ACS urges CMS to pause changes to the CY 2026 work RVUs for Current Procedural Terminology (CPT) codes 23470, 23472, 27130, and 27447, and to work with the affected specialties to develop a more robust, evidence-based process for determining alternative work RVUs before finalizing any values.

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- **G2211 transition**. Do not finalize MOD1 or MOD2 without first reconciling actual G2211 utilization with the assumptions underlying the policy, explaining the resource basis for a percentage-based payment, and publishing the distributional and budget-neutrality effects of the proposed transition, including its effect on beneficiary coinsurance across evaluation and management (E/M) levels. If CMS retains any E/M visit complexity adjustment, apply documentation and review standards at least as rigorous as those imposed for reporting modifier 22, or apply the same standard to modifier 22.

- **Same-day E/M and global periods**. Do not finalize the proposed 50 percent payment reduction. CMS has not demonstrated systematic residual duplication, established that any remaining overlap equals 50 percent, nor shown that a uniform reduction reflects the range of services affected. No reduction, including 10 or 25 percent, is appropriate.

- **Potentially Misvalued Codes**. Do not revise physician time or work RVUs for the services identified by the Maryland Healthcare Commission (MHCC) and do not conclude, based on these data, that they are potentially misvalued.

- **CPT and RUC Request for Information (RFI)**. Retain CPT as the national coding standard and preserve meaningful practicing physician involvement in code development and valuation, while continuing to improve transparency and use of objective data.

- **Individual-Level Quality Measurement Is the Common Flaw.** Across SSP, Ambulatory Specialty Model (ASM), and the MIPS Value Pathways (MVP)/Core Measures proposals, CMS continues to measure and reward individual clinicians rather than the care teams that actually deliver surgical care. This approach is statistically unreliable and incentivizes clinicians to optimize their own metrics over shared outcomes, fragmenting the coordinated care CMS's value-based agenda is meant to promote. ACS urges CMS to shift the fundamental unit of accountability to the episode and the team.

- **Adopt Programmatic, Episode-Based Quality Framework.** ACS recommends CMS adopt "programmatic measurement" that evaluates structures, processes, and outcomes at the episode level across both the care team and facility. This approach reflects shared accountability for quality and aligns naturally with an episode-based cost methodology.

- **Use Standardized, Episode-Based Cost Methodology.** ACS recommends CMS move toward standardized, episode-based cost methodologies such as the Episode Grouper for Medicare (EGM), which attribute cost across the full care team and episode, rather than continuing to rely on narrow, individual-clinician cost measures like the current MIPS episode-based cost measures (EBCMs).

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- **Specialty Care in the Shared Savings Program RFI.** ACS recommends CMS use the Long-term Enhanced Accountable Care Organization (ACO) Design (LEAD) Model (LEAD)/CMS Administered Risk Arrangements (CARA), CARA architecture as a foundation but go further: standardize core infrastructure episode definitions, data, and contracting tool—while giving ACOs and specialty teams broad flexibility to design their own care models, quality measures, and incentive distribution.

- **Ambulatory Specialty Model.** ACS has significant concerns with ASM's individual clinician-level, tournament-style design and its reliance on the failed MIPS/MVP measure framework; ACS recommends CMS delay implementation and redesign the model around team-based, risk-adjusted, episode-level accountability.

- **Fast Healthcare Interoperability Resources (FHIR)-Based Digital Quality Measures (dQMs) RFI.** ACS supports the transition to FHIR-based digital quality measurement but urges CMS to pace retirement of electronic clinical quality measures (eCQMs)/clinical quality measures (CQMs) to demonstrated infrastructure readiness—not a fixed date—and to use the transition to build genuinely team-based, patient-centered measures rather than simply digitizing existing flawed ones.

- **Mandatory MVP Transition.** ACS opposes treating the mandatory shift to MVPs as a surgical quality strategy; MVPs largely reshuffle the existing, individual-level MIPS measure inventory, and CMS should treat them as a step toward team-based, episode-based measurement rather than the endpoint.

- **Advanced Alternative Payment Models (APMs).** ACS supports applying qualified APM participants (QP)/Partial QP determinations at the Tax Identification Number (TIN)/National Provider Identifier (NPI) level and urges CMS to extend the Advanced APM incentive payment, freeze QP eligibility thresholds, and partner with specialty societies to develop APMs relevant to specialty and surgical care.

We thank CMS for their attention to these critical issues and offer more detailed comments on these and other proposals in the comments that follow.

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PROVISIONS OF THE RULE FOR PFS

Payment Adequacy and Surgical Care

Surgeons care for Medicare beneficiaries across the full continuum of care, from evaluation and diagnosis through operative treatment, postoperative management, and recovery. Surgical care frequently involves patients with cancer, cardiovascular disease, neurologic disease, traumatic injury, complex gastrointestinal disease, and other serious conditions that require continued surveillance and monitoring by the surgeon for extended periods. Maintaining access to high-quality surgical care requires a Medicare physician payment system that appropriately recognizes the resources, skill, intensity, and responsibility involved in furnishing that care.

These proposals do not arrive on neutral ground. Adjusted for practice cost inflation, Medicare physician payment declined 33 percent between 2001 and 2025, while the cost of operating a medical practice rose 59 percent over the same period.[1] The conversion factors CMS proposes for CY 2027, $33.1693 for QPs and $32.8409 for all others, are lower in raw dollars than the conversion factor in effect in 2001, before any adjustment for inflation is applied. The reductions described in this rule are further reductions layered on a payment rate that has been losing ground for a quarter century.

The figure below illustrates the combined effect of repeated conversion factor reductions and the absence of an inflationary update. Using 2016 as the base year, the first full year under the MACRA update schedule, and applying annual unadjusted Medicare Economic Index (MEI) growth in each year thereafter, the conversion factor would have reached $47.16 in 2026. The actual CY 2026 conversion factor is $33.40, which is 29.2 percent below that level. It is also lower in nominal dollars than the $35.80 conversion factor in effect in 2016, before accounting for any growth in the cost of furnishing care over the intervening decade. The increase visible in 2026 reflects the temporary 2.5 percent update that expires at the end of this year, and both conversion factors CMS proposes for CY 2027 fall below the 2026 level. This is the baseline against which the proposals in this rule should be evaluated.

[1] American Medical Association. Medicare Updates Compared to Inflation in Practice Costs (2001–2025). American Medical Association; January 2025. https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf.

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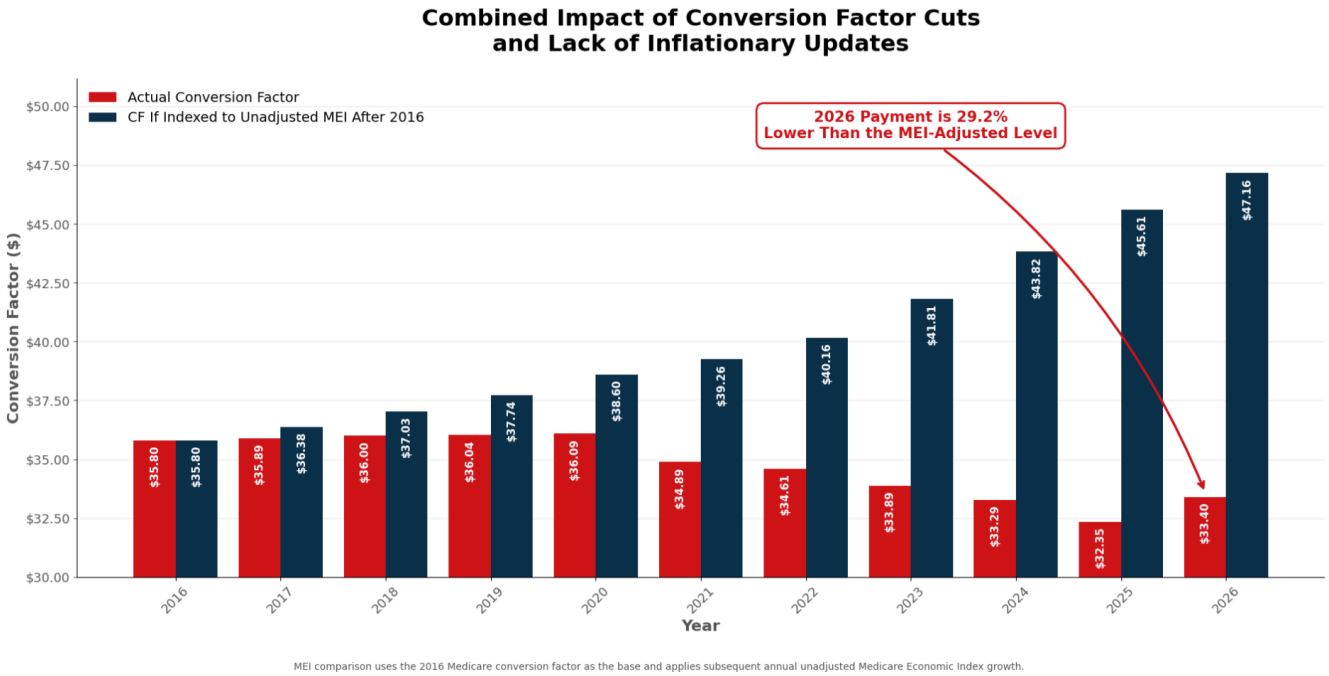
Figure 1: Combined Impact of Conversion Factor Cuts and Lack of Inflationary Updates



ACS understands that the statutory update and the budget neutrality requirement are set by Congress, and CMS cannot provide an inflation-based update through rulemaking. The distribution of payment within the fee schedule, however, is within the Agency's discretion. Each of the policies discussed below, the efficiency adjustment, the facility indirect PE reduction, the indirect PE allocator exception for global services, the same-day E/M reduction, and the imputed values for postoperative visits, reduces the relative value assigned to surgical care. A sustained decline in real payment is a reason to hold those discretionary choices to a higher evidentiary standard.

ACS supports building an update into the PFS, comparable to other Medicare payment programs, to account for the effects of inflation on the cost of providing care to seniors as a starting point to create a more stable foundation for value-based care initiatives. This inflationary update should be separate and distinct from incentives for quality and from the budget-neutral Merit-based Incentive Payment System (MIPS) incentives. One potential solution would be to provide an inflationary update to the PFS based on the MEI. We urge CMS to state its support for an inflationary update and to advance that position through CMS' legislative recommendations.

ACS is deeply concerned about the cumulative effect of Medicare payment policies on surgical and procedural care. Although CMS projects no aggregate change for general surgery from the proposed work, PE, and malpractice RVU changes, that result does not reflect the experience across surgical specialties as a whole. For example, CMS projects aggregate reductions of 9 percent for otolaryngology, 7 percent for orthopaedic surgery, 5 percent for hand surgery, 4 percent for colon and rectal surgery, 3 percent for plastic surgery, 2 percent for neurosurgery, and 2 percent for urology. Other surgical specialties are projected to experience positive or neutral aggregate effects, and individual services may move differently from the specialty average. Moreover, these estimates do not capture the negative

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impact on surgical reimbursements resulting from the proposed reductions in the conversion factor, as discussed in more detail below.

The magnitude of these specialty-level effects is not merely theoretical. Surgical organizations representing heavily affected specialties have publicly warned that the combined CY 2027 policies could destabilize independent practice, accelerate consolidation, and impair beneficiary access. ACS shares the concern that multiple simultaneous reductions (including code-specific revaluation, PE redistribution, same-day E/M reductions, and the continued application of the work RVU so-called "efficiency adjustment") should be evaluated cumulatively rather than as isolated technical changes.

Strengthening primary care and preserving access to specialty care are not competing objectives. Medicare beneficiaries need both, and payment reform should strengthen the full continuum of care. This concern is supported by recent ACS policy analysis. In May 2026, ACS surgeon leaders argued that Medicare payment reform should not be reduced to a choice between primary and specialty care, cautioning that under budget neutrality, repeated increases for one category of services necessarily create reductions elsewhere unless the underlying framework is changed. They urged policymakers to evaluate the effects of recent PFS changes before layering on additional redistributive policies and emphasized the need to preserve access to lifesaving specialty care.[2] The article was subsequently cited in materials for the May 20, 2026, hearing of the House Committee on Energy and Commerce, Subcommittee on Health, hearing on Medicare physician payment reform. ACS later highlighted the analysis as an evidence-based critique of Medicare payment reform.[3]

The same issue was also a focus of the 2026 ACS Leadership & Advocacy Summit session, "Surgery vs. Primary Care: A False Dichotomy Built into the Fee Schedule." Christopher P. Childers, MD, PhD, explained how budget neutrality, conversion factor reductions, the efficiency adjustment, and the failure to update global surgical codes commensurate with E/M revaluations can redirect resources away from procedural care. He urged policymakers to examine the evidence underlying the assumption that shifting additional PFS resources to primary care will necessarily improve population health.[4]

ACS has repeatedly warned that these annual payment changes are occurring within a broader pattern of regulatory devaluation of surgical and procedural care. In May 2026, ACS Executive Director and CEO Patricia L. Turner, MD, MBA, FACS, emphasized that quality surgical care depends on access and that continued instability in the Medicare Physician Fee Schedule threatens timely access to surgical and specialty care. [5] ACS has likewise urged Congress to adopt long-term payment reform that reflects

[2] Childers CP, Senkowski CK, Selzer DJ, et al. Modernizing the Medicare physician fee schedule: what problem are we trying to solve? Health Aff Forefront. May 8, 2026.
[3] American College of Surgeons. Surgeon experts highlight a core problem of Medicare payment reform in Health Affairs. May 12, 2026.
[4] American College of Surgeons. Surgeons bring their case to Capitol Hill at 2026 Advocacy Summit. April 2026.
[5] American College of Surgeons. ACS urges Congress to stabilize Medicare physician payment and protect access to surgical care [press release]. May 20, 2026. https://www.facs.org/media-center/press-releases/2026/acs-urges-congress-to-stabilize-medicare-physician-payment-and-protect-access-to-surgical-care/

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inflation in practice costs, reduces disruptive budget-neutrality adjustments, and preserves the surgical workforce.[6]

We urge CMS to state its support for an inflationary update to the PFS and to advance that position through CMS' legislative recommendations. CMS measures the growth in practice costs every year and relies on those measures throughout the fee schedule, including in the productivity figure underlying the efficiency adjustment. The Agency is therefore well positioned to explain to Congress why a payment system that measures the rising cost of care but does not reflect it in the update is not sustainable. Until Congress acts, the Agency's discretionary choices within the fee schedule carry the full burden of maintaining payment adequacy, and this rule illustrates the consequences.

Physician Work Efficiency Adjustment

CMS is not proposing changes to its so-called "efficiency adjustment" policy for CY 2027. The 2.5 percent cut to non-time-based services that CMS finalized for CY 2026 continues to undervalue the work RVUs and corresponding intraservice time of most non-time-based surgical services. CMS has also finalized a policy to implement additional cuts to the intraservice portion of physician time and to work RVUs every three years, indefinitely.

ACS continues to oppose the underlying assumption that surgical physician work predictably becomes more efficient over time merely because economy-wide productivity increases. We continue to stress that changes in physician work should be based on service-specific clinical and empirical evidence, which this policy lacks.

ACS has tested that assumption against clinical data. An analysis of more than 1.7 million operations across 249 CPT codes and 11 surgical specialties found that operative times increased 3.1 percent overall between 2019 and 2023 and that 90 percent of procedures had the same or longer operative times. Measures of patient complexity also increased.[7] Additional ACS-led research reinforces why a generalized efficiency assumption is particularly ill-suited to surgery. In an analysis of 158,692 common abdominal operations, increasing obesity was associated with progressively longer operative time and greater complication risk; operative time was approximately 27 percent longer among patients with extreme obesity than among patients with normal body mass index.[8]

Changes in operative approach can create a similar problem for historical valuation. As minimally invasive techniques become the predominant approach for many procedures, the patients who require an open operation or conversion to open surgery may represent a more complex clinical population. ACS-led research has examined this phenomenon and its implications for the PFS. These findings illustrate

[6] See note 4. See also Turner PL. Statement before the US Senate Committee on Finance: bolstering chronic care through Medicare physician payment. April 11, 2024.
[7] 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;241(5):741-744.
[8] Childers CP, Petty AM, Selzer DJ, et al. Obesity and work in abdominal surgery. *J Am Coll Surg*. 2025;241(3):357-363.

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that technological progress may change the mix and complexity of patients represented by a code rather than simply making the physician work easier.[9]

Technological advances can improve outcomes and expand treatment options without reducing physician work. In many cases, advances permit surgeons to operate on older, sicker, and more complex patients. CMS' so-called "efficiency adjustment" also compounds other valuation pressures on surgery, including global code payment where embedded E/M relativity has not been updated to reflect increases made to analogous stand-alone E/M services.

We also stress that the premise that surgical services will continue to become more efficient indefinitely is erroneous. This assumes that all physicians are at the same level of experience and simultaneously become equally efficient. In reality, the amount of time each physician takes can vary. For example, newly trained physicians may take longer than more experienced physicians to furnish a given procedure, and experienced physicians who take on challenging cases or are teaching other physicians who are new to the procedure will require more operative time.

The effects of this procedure penalty implemented by CMS also extend beyond the Medicare program because work RVUs are widely used in employed physician contracts through compensation arrangements. Dr. Childers and Don J. Selzer, MD, FACS, have described the difficulty created when CMS reduces work RVUs before external productivity benchmarks can incorporate the change, leaving institutions and surgeons without contemporaneous empirical benchmarks.[10] This downstream effect provides an additional reason for CMS to require strong service-specific evidence before applying generalized reductions to physician work.

In July 2026, ACS welcomed bipartisan legislation proposing an annual inflationary update and a higher budget-neutrality threshold but noted that the legislation did not address the efficiency adjustment or the payment reductions scheduled for CY 2027.[11] ACS therefore continues to view CMS' so-called "efficiency adjustment" as an unresolved structural problem rather than a completed CY 2026 policy issue.

ACS urges CMS to repeal the "efficiency adjustment" policy and, at a minimum, not to treat its continued application as evidence that affected surgical services have become more efficient.

<u>Determination of PE RVUs</u>

Create the Indirect Cost PE RVUs

Below, we address several proposed changes to the PE methodology. ACS appreciates CMS' continued efforts to improve PE accuracy within the constraints of the PFS. Statutory budget neutrality means increases in relative resources attributed to one set of services generally must be offset by reductions elsewhere. ACS recognizes that CMS cannot eliminate the statutory budget neutrality requirement

[9] Childers CP, Sutherland MJ, Selzer DJ, et al. Characteristics of open and conversion to open operations in a minimally invasive era: implications for the physician fee schedule. *J Am Coll Surg*. Published online April 9, 2026.
[10] Childers CP, Selzer DJ. Recalibrating productivity benchmarks. *JAMA Surg.* 2026;161(6):562-563.
[11] American College of Surgeons. Bipartisan Medicare payment reform bill is introduced. July 21, 2026.

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through regulation, but continued redistribution of a constrained physician payment pool is not sustainable.

- **"Step 8" Modification to the Indirect PE Allocator**

CMS proposes to revise Step 8 of the PE methodology by allocating indirect PE using the sum of the work RVUs and the clinical labor portion of direct PE for most PFS services. CMS would, however, exclude services with 10- and 90-day global periods and continue to allocate indirect PE for those services using only the higher of the work RVU or clinical-labor PE RVU. This distinction is consequential for surgery. Services moved to the sum methodology receive recognition for both physician work and clinical labor in the indirect allocator, while 10- and 90-day global surgical services remain subject to a methodology that recognizes only the larger of those two components. As a result, the proposal creates a structural disadvantage for global surgical services in the allocation of the fixed indirect PE RVU pool.

The exclusion is also a departure from the methodology evaluated in the CMS-commissioned RAND study that modeled the sum of work RVUs and clinical-labor PE RVUs without excluding 10- and 90-day global services. CMS has not provided a resource-based rationale for treating the presence of a global period as a basis for effectively disregarding one of these resource components when allocating indirect PE. Global surgical services include substantial physician work and clinical staff resources for scheduling, care coordination, preoperative preparation, postoperative management, patient communications, and other clinical activities. Payment as a global package does not eliminate these underlying resource costs.

The proposed exception is particularly concerning because the indirect PE pool is budget neutral. Expanding the use of the sum of work and clinical labor allocator for some services necessarily reduces the relative share available to services that remain under the higher-of (work or clinical labor) methodology. Thus, even if CMS does not characterize the global code exception as a reduction, services with 10- and 90-day global periods can lose relative PE simply because other services are permitted to count both work and clinical labor while global services are not.

If CMS believes global surgical services warrant different treatment, the Agency should: (1) explain the resource-based rationale for the exception; (2) quantify the amount of indirect PE redistributed as a result; and (3) publish code- and specialty-level estimates showing the effect of the Step 8 change. This transparency is necessary to determine whether the exception improves resource-based relativity or functions as another punitive policy for services paid through a global surgical package. Until such information is provided, **ACS urges CMS to apply the sum of both work RVUs and clinical-labor PE RVUs consistently to all services, including 10- and 90-day global services.**

- **Removal of the IPCI**

CMS proposes to phase out the IPCI, which currently adjusts indirect PE allocations using specialty-specific practice expense per hour data. For CY 2027, CMS would apply only one-half of the variation currently reflected through the IPCI; beginning in CY 2028, the IPCI would no longer be applied. CMS

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would correspondingly remove Steps 12 through 17 of the PE methodology, which are the technical steps through which the IPCI-based specialty-level rescaling is implemented.

ACS recognizes CMS' concern that the specialty-specific PE/hour data underlying the IPCI are outdated. However, removing the IPCI does not replace those data with current specialty-specific information about the costs of operating a physician practice. Instead, it removes an existing specialty-level adjustment and allows the preceding elements of the PE methodology to determine a greater share of the final PE RVU. The result is a significant redistribution of PE across specialties and services. **ACS urges that CMS delay implementation until the Agency has demonstrated that the proposed methodology produces more accurate resource-based relativity rather than assuming that eliminating an older data source necessarily produces a more accurate result.**

Calculate the Final PE RVUs

- **PE Stabilization Adjustment**

CMS separately proposes a PE stabilization adjustment that would generally limit the annual change in a code's PE RVUs to +/-5 percent relative to the prior year. CMS' stated goal of the stabilizer is to slow the movement of affected services toward their fully implemented PE values; it would not change those underlying target values nor eliminate the redistribution produced by the revised methodology. CMS proposes exceptions for new and revised services, newly nationally priced services, and revalued services. CMS also contemplates continuing the stabilizer after the IPCI has been fully eliminated, meaning that some services could continue moving toward their fully implemented PE values in years after CY 2028.

ACS supports the goal of protecting physicians from abrupt annual PE RVU changes, but the proposed stabilizer is not a substitute for a deliberate transition to a major new PE methodology. A +/-5 percent annual cap at the code level can result in different services reaching their fully implemented values at different times, and it does not provide physicians or other practitioners with a predictable transition period. CMS has previously used a four-year transition when implementing a significant PE methodology change, including the transition to the bottom-up PE methodology beginning in CY 2007 and the incorporation of specialty-specific Physician Practice Information Survey data beginning in CY 2010.

The CY 2027 proposals to modify the indirect PE allocator, phase out the IPCI, modify utilization assumptions, and establish a stabilization adjustment follow a significant CY 2026 change to indirect PE for facility services. Our analysis demonstrates that the first-year PE effects for general surgery differ materially from the fully implemented results in both facility and non-facility settings. Providers and medical practices cannot make reliable budget assumptions based solely on the first year of an unpredictable multi-year change.

ACS urgently requests that CMS implement a four-year transition period for any finalized changes to the PE methodology. In addition, **CMS must ensure transparency for any change and its associated transition by publishing public files that include (1) annual and fully implemented**

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code-level PE RVU changes for each distinct PE methodology change; and (2) specialty-level impact tables for each distinct PE methodology change.

Updates to PE Methodology - Site of Service Payment Differential

ACS continues to oppose the CY 2026 policy that reduces by 50 percent the work RVU component used to allocate indirect PE for services furnished in the facility setting. The policy rests on a broad assumption that physicians furnishing services in facilities incur substantially fewer indirect practice expenses than physicians furnishing services in non-facility settings. However, site of service alone does not establish whether that assumption is true for a particular physician, practice, or service.

The CY 2027 proposed rule itself illustrates the limitations of such a binary approach. CMS acknowledges that physicians practice under a wide range of employment, ownership, contractual, and organizational arrangements and seeks comments on whether indirect PE should instead reflect whether a physician is employed by a hospital or health system and which entity actually incurs the relevant costs. CMS also asks whether the current 50 percent allocation may still be too high for some hospital employed physicians, potentially including circumstances in which the appropriate allocation could be zero.

ACS strongly cautions against moving from one unsupported uniform assumption to another. Before reducing facility indirect PE below the current level, CMS should identify the specific indirect costs it believes are borne by the facility rather than the physician practice, determine whether those costs are already recognized through another Medicare payment, and quantify the amount of actual duplication. The fact that a service is furnished in a hospital does not establish that the surgeon's practice ceases to incur costs for billing, coding, scheduling, compliance, information technology, practice management, professional liability administration, personnel, and other infrastructure necessary to support the surgeon's professional services.

In addition, the wide variation in surgical practice arrangements makes a site-of-service proxy particularly problematic. The 2024 AMA Physician Practice Benchmark Survey found that 81.4 percent of independent general surgeons and 77.1 percent of independent surgical subspecialists provide weekly patient care in both facility and non-facility settings.[12] All of these surgeons have been impacted by the 2026 policy that reduced reimbursement under the false assumption they were employed and not incurring indirect practice expenses just because they performed an operation in a facility.

If CMS ultimately determines that employment or another business arrangement provides a more accurate means of identifying circumstances in which indirect costs are borne by a facility, any such policy must operate at the service or claim level rather than at the physician level. Surgeons may have different employment, contractual, and practice arrangements across locations and services. Classifying a physician globally as “employed” or “independent” would simply substitute a different inaccurate proxy for the current facility/non-facility distinction.

[12] Kane CK. Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties. American Medical Association; 2025.

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CMS would also need to define "employed" and "independent" with precision. Employment status alone may not establish which entity incurs particular costs. Contracted physician groups, faculty practices, professional corporations, joint ventures, leased arrangements, and other models may divide administrative and overhead responsibilities differently. The relevant inquiry should be what resource costs are associated with the particular professional service, not the organizational label attached to the physician for any single service.

CMS seeks comment on whether a new HCPCS modifier could identify services furnished by hospital- or health-system-employed physicians. If CMS pursues such an approach, the reporting obligation should rest with the entity or practice possessing reliable information about the employment arrangement and should apply only to the particular services for which the relevant costs are demonstrably borne elsewhere.

We reiterate our suggestion about alternative approaches that would better enable the Agency to tackle its stated concerns regarding the indirect PE differentials:

Option A: Employed provider modifier and PE RVU adjustment factor. CMS could develop a new HCPCS modifier, such as "FE" for "facility-employed" provider, that would be appended to claims for services furnished by providers who are employed by the facility in which they provided the services. When modifier "FE" is reported, it would trigger an adjustment factor to the PE RVU calculation, 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:

PFS Facility Payment =

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

In this formula:

- 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, if applicable.

The ACS continues to have significant concerns regarding how such an adjustment factor would be quantified given CMS' lack of data and its failure to recognize the additional costs associated with supporting services provided by an employed physician. Nevertheless, this approach could address

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potential cost differentials without unjustly denying resource payments for either facility or non-facility claims from physicians who are not employed by the facility where the service is furnished. On the other hand, an FEI would need to be created for every code since the indirect PE RVUs vary from code to code and an across-the-board percent adjustment is not possible.

Option B: Employed provider modifier and new "employed non-facility PE RVU" component. As described above, CMS could develop a new HCPCS modifier, such as "FE" for "facility-employed" provider, that would be appended to claims for services furnished by providers who are employed by the facility in which they provided the services. In this option, the Agency could then create a third PE RVU column, in addition to the existing facility and non-facility PE RVU columns. When modifier "FE" is appended to a claim, payment would be determined using the new third column of PE RVUs for employed providers.

Option B is more straightforward as it would use the PE methodology equation and be tailored to each code. However, either approach would allow CMS to more narrowly target potential (but yet to be quantified) 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 providers not employed by the facility where the service is furnished. Approaches such as those offered above would also ensure that providers are not wrongfully impacted by a policy that is ultimately meant to address the indirect PE costs that are reimbursed in a facility fee. These options would also maintain the RVUs assigned to facility services, which would avoid disrupting RVU-based provider employment contracts.

Furthermore, both approaches align with the Medicare Payment Advisory Commission (MedPAC's) recent recommendations to analyze clinician affiliation data. We however disagree with MedPAC suggestion to implement claim-based identifiers associated with a physician's primary practice setting (e.g., facility-based, non-facility-based, combined). As we previously indicated, a physician can be in an independent practice and separately also have a hospital contract to provide services. Use of a claims-based modifier would allow accurate reporting for each service.

Absent empirical evidence identifying specific duplicated resources and supporting the magnitude of any reduction, CMS should not further reduce facility indirect PE, including to zero for any category of physicians. Any future methodology should be resource-based, narrowly tailored, applied at the service or claim level, and sufficiently flexible to reflect the wide variety of contemporary physician practice arrangements. Accordingly, **ACS urges CMS to repeal the CY 2026 50 percent facility indirect PE adjustment and, if necessary, consider implementing an HCPCS modifier and additional PE RVU component as discussed above.**

Global Surgical Packages

CMS is seeking comment on possible future approaches to global surgical payment and has released a public use file displaying imputed postoperative-visit RVUs using a purely arithmetic approach. **ACS has significant concerns with using these data or this arithmetic approach to support future widespread reductions in global surgical service values.**

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ACS supports CMS' proposal to pause the 99024 claims-based reporting requirement and urges CMS not to rely on the data collected under that requirement to revalue global surgical services.

History of CMS Policy on Global Surgical Packages

The history of this issue is important. In the CY 2015 PFS final rule, CMS finalized a policy to transition 10- and 90-day global surgical services to 0-day global periods. Under that policy, postoperative visits furnished after the day of the procedure would have been removed from the global package and billed separately as standalone services. Congress subsequently prohibited CMS from implementing that policy through section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and instead directed CMS to collect information on postoperative services and use that information to improve the accuracy of global surgical service valuation.

ACS has previously addressed these issues directly with CMS as well as with MedPAC. In an April 23, 2025, letter to MedPAC, ACS emphasized that global surgical payment was designed around the typical patient and that variation in postoperative care is expected to average across patients rather than requiring identical follow-up for every beneficiary. ACS also documented the long history of redistribution away from surgical services under the Resource-Based Relative Value Scale (RBRVS) and explained that CMS' CY 2021 increases to stand-alone office/outpatient E/M services were not accompanied by corresponding increases to the E/M work embedded in global surgical packages.[13,14]

Beneficiary Cost-Sharing and Access Must Be Considered

The existing global surgical package includes routine postoperative care related to the procedure rather than separately billing the beneficiary for each included postoperative visit. Conversion to a 0-day global period would make postoperative visits furnished after the day of surgery separately reportable and payable, with corresponding Medicare cost-sharing. Separate cost-sharing at individual postoperative encounters will affect whether beneficiaries return for recommended follow-up care. Scheduled follow-up care is important.[15] Missing or delaying scheduled postoperative visits is associated with concrete, serious harms: unmonitored surgical site infections that progress to readmission and reoperation; wound dehiscence and other healing failures requiring additional procedures; and delayed recognition of bleeding, thromboembolic events, organ dysfunction, and other complications that increase morbidity and mortality. In orthopaedic and upper-extremity surgery, patients lost to follow-up experience significantly worse long-term outcomes, and in cataract surgery, missed postoperative visits impede detection of vision-threatening complications. For procedures requiring long-term postoperative therapy (e.g., valvular surgery), nonadherence to follow-up and monitoring is linked to stroke, thromboembolism, and increased mortality. Accordingly, any future consideration of eliminating 10- and 90-day global periods should evaluate how additional per-visit

[13] American College of Surgeons. Letter to the Medicare Payment Advisory Commission regarding global surgical payment policy. April 23, 2025.
[14] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. MedPAC; June 2025:chap 1.
[15] Javed H, Olanrewaju OA, Ansah Owusu F, et al. Challenges and solutions in postoperative complications: a narrative review in general surgery. *Cureus*. 2023;15(12):e50942.

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cost-sharing for postoperative care risks deterring necessary follow-up and undermining patient safety and outcomes.[16]

99024 Reporting Requirement

CMS proposes to pause the claims-based reporting requirement under which selected practitioners report CPT 99024 following specified global surgical procedures and seeks comment on whether other data sources could better support global surgery valuation.

ACS supports the proposed pause

ACS has repeatedly and extensively commented throughout this data-collection effort that the resulting information is not sufficiently reliable to support revaluation. The reporting population is narrow; the required reporting code (99024) is non-payable and therefore lacks any billing incentive to drive consistent submission; and even when captured, the code merely indicates that a postoperative visit occurred without capturing its level, intensity, or clinical content. These are fundamental methodologic flaws that additional years of data collection will not remedy.

The HHS Office of Inspector General (OIG) reached comparable conclusions in its own audit of the data. The OIG found that the postoperative visit data CMS gathered for 45 of the 105 sampled global surgeries were inaccurate and could not assist in improving global surgery valuation as Congress intended. They attributed much of the underreporting to practitioners and their staff being unfamiliar with the collection requirement and to billing systems that were not configured to submit a non-payable code, and they found that CMS had not provided sufficiently clear information about who was required to report and what was to be reported.[17] ACS interprets those findings as confirmation that the collected data are insufficient to support revaluation, regardless of what conclusions may be drawn about utilization.

ACS Opposes the Approach and Values CMS' Posts in the "Purely Arithmetic" Imputed RVUs File

A fundamental flaw in any effort to use these data for RVU valuation is the reliance on a reverse building block methodology. Since the inception of the RBRVS, magnitude estimation has been recognized as the validated method for creating a relative value scale, as established through psychometric evaluation in the original 1980s Hsiao papers. The work RVUs for global surgical services were established using magnitude estimation. The postoperative visit assumptions used in that process informed the overall magnitude estimate; they were not independently valued, severable building blocks that were mechanically added together to produce the final work RVU. **It therefore is not appropriate to reverse that process now by assigning an RVU amount to assumed postoperative visits and subtracting that amount from the current work RVU.** Doing so would produce rank order anomalies

[16] Centers for Medicare & Medicaid Services, Medicare Learning Network. Global surgery booklet. MLN907166. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2015, 79 Fed. Reg. 67548, 67582-67591 (Nov. 13, 2014).
[17] US Department of Health and Human Services, Office of Inspector General. CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries. Report A-05-20-00021. June 2025.

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and a system that is no longer relative. Only the physicians who perform a service are capable of precisely determining the relative work it requires and balancing the totality of the pre-service, intra-service, and post-service work.

Setting the methodology aside, the underlying data cannot support the use of a reverse building block methodology. The file is premised on the 99024 collection effort and RAND's analysis of that flawed and limited data. As described above, those data are unreliable, and we agree strongly with CMS' proposal to pause the collection. Arithmetic does not cure the underlying limitations. CPT 99024 indicates only that a postoperative visit occurred. It does not identify whether the visit was furnished in an inpatient or outpatient setting, or at what level of service. Nor can CMS treat the time file as accurate for one purpose and inaccurate for another. The imputed values assume that the average visit level reflected in the time file is correct while simultaneously assuming that the number of visits in that same file is not.

The consequences are visible in CMS' "Global Surgical Services Summary" public use file. Comparing work per unit time (WPUT) for office E/M services against codes truncated to a 0-day global equates the single-day time commitment of a physician furnishing an office E/M visit with that of a surgeon performing a procedure in a facility. If the 9.24 postoperative E/M work RVUs were removed from the CY 2026 90-day global work RVU of 17.04 for CPT 47600 (cholecystectomy) to create a 0-day global code, the resulting WPUT would be 0.036, well below the 0.043 WPUT for a mid-level established office visit (CPT 99213). The disparities are greater still for CPT 35701 (exploration, neck artery, not followed by surgical repair), at 0.031, and CPT 37607 (ligation or banding of angioaccess arteriovenous fistula), at 0.025.

CMS has not demonstrated that the available postoperative visit data establishes widespread overvaluation of 10- and 90-day global surgical services. The 99024 claims do not identify the level of the visits they report, RAND's empirical visit-level work was limited to three procedures, and the arithmetic revaluation methodology does not reflect the magnitude-estimation process used to establish global surgical work RVUs. **ACS therefore urges CMS not to use the current postoperative visit data or the "purely arithmetic" values displayed in the public use file to make widespread reductions to 10- and 90-day global surgical services, and not to view conversion to 0-day global periods as a ready alternative.**

CMS Should Rely on ACS as a Resource for Improving the Accuracy of Global Surgery Code Values

ACS supports data-driven efforts to ensure the accuracy of services recognized under the PFS. Any future analysis must also account for the fact that E/M services embedded in global surgical packages have not been fully updated to reflect increases made to analogous stand-alone E/M services beginning in 2021 and subsequent changes to inpatient and observation E/M services. Under the 0-day policy CMS previously finalized, postoperative services removed from the package would have become separately reportable and payable at the E/M values applicable when furnished. A future policy that instead retains the global period while reducing the package based on current postoperative utilization would leave surgeons responsible for the postoperative care while preserving older E/M relativity inside the package.

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ACS does not believe that asymmetry can be ignored in any assessment of global surgical payment accuracy. ACS is prepared to work with CMS on a methodology that captures the level and content of postoperative work, and we request a meeting to discuss how the College's clinical and coding expertise can support that effort.

Payment for Medicare Telehealth Services

Telehealth Critical Care Consultations

ACS supports CMS' efforts to clarify billing for telehealth critical care consultations. CMS proposes to revise HCPCS code G0508 to describe the first 30 to 74 minutes of a telehealth critical care consultation and G0509 to describe each additional 30 minutes. ACS supports clear descriptors that align reporting with the time actually furnished and urges CMS to preserve physician judgment regarding when critical care consultation can be safely and effectively furnished through telehealth.

Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

ACS supports CMS' proposal to allow teaching physicians to bill for eligible Medicare telehealth services involving residents when either the teaching physician or the resident is physically present with the beneficiary, rather than requiring all three participants to be in separate locations. The proposal better reflects contemporary teaching arrangements while maintaining an in-person clinical presence with the patient. CMS should preserve appropriate flexibility for teaching programs while ensuring that the teaching physician remains meaningfully involved in the service.

Valuation of Specific Codes, Including Potentially Misvalued Codes

Valuation of specific codes

- **Diaphragmatic Hernia Repair (CPT Codes 39540, 39541, 39XX3, 39XX4, 39XX5, 39XX7, 39XX8, 39XX9, 39X11, 39X12, and 39X13)**

CMS proposes the RUC-recommended work RVUs of 24.00 for CPT code 39540, 26.00 for CPT code 39541, 25.75 for CPT code 39XX3, 26.41 for CPT code 39XX4, 25.94 for CPT code 39XX5, 22.04 for CPT code 39XX7, 26.60 for CPT code 39XX8, 27.00 for CPT code 39XX9, 25.44 for CPT code 39X11, 25.94 for CPT code 39X12, and 3.00 for CPT code 39X13. CMS also proposes the RUC-recommended direct PE inputs for the family without refinement. ACS supports acceptance of the RUC recommendations.

- **Congenital Duodenal Obstruction Repair (CPT Codes 44XX1 and 44XX2)**

CMS proposes the RUC recommended work RVUs of 50.00 for CPT code 44XX1 and 52.60 for CPT code 44XX2 and proposes the RUC recommended direct PE inputs without refinement. ACS supports acceptance of the RUC recommendations.

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- **Irreversible Electroporation of Tumor, Pancreas (CPT Code 48XXX)**

CMS proposes the RUC recommended work RVU of 25.19 for new CPT code 48XXX and the RUC recommended direct PE inputs without refinement. ACS supports acceptance of the RUC recommendations.

- **Division of Median Arcuate Ligament (CPT Codes 39XX1 and 39XX2)**

CMS proposes efficiency adjusted RUC recommended work RVUs of 26.41 for CPT code 39XX1 and 25.94 for CPT code 39XX2 and proposes the RUC recommended direct PE inputs without refinement. ACS supports acceptance of the RUC recommendations.

- **Diaphragm Repair (CPT Codes 39545 and 395X2)**

CMS proposes the RUC recommended work RVUs of 18.45 for CPT code 39545 and 20.00 for CPT code 395X2 and proposes the RUC-recommended direct PE inputs for both services without refinement. ACS supports acceptance of the RUC recommendations.

ACS' support for CMS accepting the RUC recommendations for these newly described procedures should not be interpreted as endorsement of the separate physician work efficiency adjustment that the Agency applied. As discussed above, ACS continues to oppose applying a generalized efficiency assumption to surgical physician work without service-specific evidence demonstrating that the work required to furnish the service has become less intensive.

- **Major Joint Arthroplasty (CPT Codes 23470, 23472, 27130, and 27447)**

CMS proposes work RVUs below the RUC recommended values for these arthroplasty services, relying on reductions in surveyed time and on crosswalks to services the Agency identified as comparable. While ACS defers to the AAOS on the clinical specifics of these procedures, we comment because the reasoning CMS applies here is not confined to orthopaedic surgery. It reflects assumptions about time, site of service, and comparability that would affect the valuation of surgical services across specialties if applied as a general approach.

First, a reduction in measured intraservice time is not evidence of a proportional reduction in physician work. Where the same or more complex work is accomplished in less time, intensity increases. The RUC survey process is designed to capture that relationship, and CMS should not treat shorter time as a standalone basis for reducing work RVUs.

Second, migration from inpatient to outpatient status does not establish that a procedure has become less complex, less intense, or requires less work. We continue to disagree with CMS' policy of diminishing physician work for an overnight stay to one-half of a discharge management service as if the patient went home the same day. Caring for a patient who requires an overnight stay, a full E/M service later that day, and another E/M service the next day before it is safe to discharge is not the same work as caring for a patient discharged several hours after a procedure on the same day. Site of service reflects changes in perioperative management, facility capability, and payment policy. It is not a measure of the

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operative work required to furnish the service. As discussed above in connection with CMS' so-called "efficiency adjustment," changes in the site and manner of care delivery frequently coexist with stable or increasing physician work.

Third, the crosswalks CMS selected emphasize time without adequately accounting for clinical intensity, technical complexity, reconstruction risk, and intensive postoperative physician work. Several of the comparator services differ materially from the arthroplasty codes on these dimensions. A crosswalk that matches on time alone does not establish relativity.

Fourth, the available claims data do not show that these patients have become less complex. Analysis of Medicare fee-for-service claims before and after these procedures were removed from the inpatient-only list shows that Charlson Comorbidity Index values remained consistent across cohorts.

Fifth, these are not newly examined services. CPT 27130 has been reviewed five times, in 2007, 2010, 2014, 2021, and 2025. CPT 27447 has been reviewed six times, in 2005, 2007, 2010, 2014, 2021, and 2025. CPT 23472 has been reviewed five times, in 2005, 2007, 2010, 2013, and 2025. The early reviews of these codes produced modest increases. Every review of all three codes since 2013 has reduced the value. The values CMS proposes for CY 2027 would be the fourth consecutive reduction for total hip and total knee arthroplasty and the third for total shoulder arthroplasty. Each of those prior reviews used survey data from the physicians who furnish these services, and CMS accepted the resulting values at the time. A valuation process that produces a further reduction at every review for more than a decade is not converging on an accurate value.

The CMS proposed work RVUs for these codes represent a significant departure from the valuation approach previously applied to these services, with correspondingly significant payment effects. The evidentiary basis for a change of this magnitude should be strong, and it is not met by inferences drawn from reduced time and site-of-service migration.

ACS urges CMS to pause changes to the CY 2026 work RVUs for CPT codes 23470, 23472, 27130, and 27447 and to work with the affected specialties to develop a more robust, evidence-based process for determining alternative work RVUs before finalizing any values.

- **National Payment for Non-Sheet Form Skin Substitutes**

CMS proposes to nationally price non-sheet form skin substitutes consistent with the payment rates associated with sheet-form skin substitutes, using square centimeters of wound surface area treated for non-sheet products. **ACS supports CMS' goal of establishing a predictable national payment methodology but urges the Agency to ensure that the methodology reflects the actual resources required for clinically appropriate wound care and does not create incentives based solely on product form**.

- **Hyperbaric Oxygen Under Pressure (HCPCS Code G0277)**

CMS proposes to retain HCPCS code G0277 because it is used across multiple Medicare payment systems to report the time a beneficiary receives hyperbaric oxygen therapy. The RUC recommended

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deletion of G0277 together with revision of CPT code 99183 to create a single time-based coding structure for treatment delivery, attendance, and supervision. **ACS urges CMS to continue working with the RUC and affected specialties toward a coding structure that accurately describes the service while avoiding unnecessary duplication or administrative complexity**.

- **Ultrasonic Wound Assessment (CPT Code 97610)**

CMS agrees with a nomination identifying CPT code 97610 as potentially misvalued and proposes to reduce the direct PE price for supply code SA119 to $100 while requesting paid invoices. **ACS supports use of current, verifiable invoice information when pricing supplies, but urges CMS to base any final price on representative acquisition-cost evidence rather than a single manufacturer's public materials or inferred sales-price calculations**. The Agency should consider submitted invoices and other market evidence before finalizing the direct PE input.

E/M VISIT COMPLEXITY ADD-ON CODE G2211

Proposed Transition from G2211 to MOD1 and MOD2

CMS proposes replacing HCPCS G2211 with percentage-based modifiers rather than a fixed add-on payment. Under the proposal, MOD1 would increase payment for the associated eligible office/outpatient E/M service by 16 percent, while MOD2 would provide a 32 percent increase for qualifying clinicians participating in Accountable Care Organizations. This is not merely a change in claims mechanics. A fixed add-on payment applies the same dollar amount regardless of E/M level, while a percentage-based modifier directs progressively more dollars to higher-level E/M services.

ACS continues to question the assumptions underlying the implementation of HCPCS G2211. CMS initially projected G2211 utilization on roughly 36 percent of eligible outpatient E/M visits, with substantially higher utilization anticipated as the policy matured. ACS analysis of the 2024 Medicare 5 percent Carrier file found G2211 reported with approximately 11 percent of eligible visits across codes and settings. Even among level 4 and level 5 established patient visits, utilization remained below 20 percent; at level 3 and below, utilization was approximately 5 percent or less. The substantial gap between projected and actual utilization warrants examination before CMS replaces the existing code with a new percentage-based payment structure.

ACS is also concerned about relativity. The CMS rationale for G2211 is visit complexity associated with longitudinal or continuing care, but a percentage-based payment produces a larger absolute increase for higher level E/M services even though the underlying complexity concept can apply across E/M levels. CMS should explain why the resources associated with the G2211 concept increase proportionately with the base E/M payment and how the proposed 16 percent and 32 percent amounts were derived.

The absence of a demonstrated resource basis for this change is central to our concern. CMS has not identified any resource, in time, intensity, clinical staff, or supplies, that a practitioner will furnish in CY 2027 that was not already furnished when the same visit was reported with G2211 and further, when the same visit was reported with a prolonged services code and/or a principal, chronic, or complex care management code. The visit complexity concept itself is unchanged. What changes is the payment

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mechanism and its distribution across E/M levels. A percentage-based adjustment would be defensible if CMS demonstrated that the additional work associated with the complexity concept increases as the level of the base visit increases, such that the increment accompanying a level 5 visit genuinely exceeds the increment accompanying a level 3 visit. CMS has not substantiated this claim. **Absent such evidence, the 16 percent and 32 percent adjustments operate as amounts calibrated to reproduce an aggregate spending result under budget neutrality rather than as measures of the resources involved in furnishing the service**.

The choice of mechanism also has consequences for beneficiaries that the proposed rule does not address. Because Part B coinsurance is calculated as a percentage of the allowed amount, a fixed add-on payment produces the same additional beneficiary liability regardless of the level of the associated visit. A percentage-based modifier does not. Beneficiaries whose visits are reported at higher E/M levels will pay more in coinsurance than they do under G2211 today, while beneficiaries whose visits are reported at lower levels will pay less. The practical effect is to increase cost-sharing for the beneficiaries whose visits are the most complex, who are generally the beneficiaries who are the sickest. ACS does not object to beneficiary cost-sharing that tracks demonstrated differences in the resources required to furnish care. We do, however, object to a redistribution of cost-sharing that follows from the selection of a payment mechanism rather than from any showing about the care actually furnished. As discussed above in connection with global surgical services, beneficiary liability should be an evaluated element of payment design rather than an incidental consequence of it.

In addition to opposing the basis for G2211, we further strongly oppose replacing the transparent, separately reported G2211 add-on code (which appears on every beneficiary's explanation of benefits and is subject to standard Part B cost-sharing) with an opaque percentage increase in allowed charges for E/M services. Such a backdoor change would effectively conceal the additional patient cost-sharing for unproven "visit complexity" by embedding it within the base payment rather than reporting it as a distinct, reviewable line item.

More broadly, ACS remains concerned about layering any additional complexity payments (e.g., G2211 or modifiers) onto an E/M system that already includes level selection based on medical decision making or time and separate additional reporting of prolonged service codes and/or a principal, chronic, or complex care management code. The current modifier proposal may create new rank order and relativity issues within the PFS. If CMS believes an additional complexity adjustment remains necessary, the Agency should demonstrate the distinct resources being recognized and ensure that comparable mechanisms for recognizing unusually intensive procedural work are not subject to materially different documentation and payment standards.

Modifier 22

ACS also urges CMS to address the disparity between how the program recognizes complexity in E/M services and how it recognizes unusual complexity in procedural services. Modifier 22 was designed for precisely the purpose that G2211, MOD1, and MOD2 are intended to serve on the E/M side: identifying an individual service that required substantially greater work than the typical case and adjusting payment

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accordingly. Modifier 22 is the existing mechanism for recognizing that the resources involved for a particular procedure exceeded what the code value assumes.

In practice, however, Modifier 22 does not function as a comparable payment mechanism. An analysis of 2021 Medicare fee-for-service claims by Dr. Childers and colleagues examined modifier 22 use across a diverse panel of surgical procedures and found little to no associated financial benefit. The largest observed effect was for kidney transplant, where mean payment increased by approximately $71, a relative increase of 3.4 percent. The authors concluded that surgeons have little reason to request Modifier 22 and that no mechanism currently exists for surgeons to recoup payment for difficult operations.[18] Reporting the modifier nonetheless requires supporting documentation and subjects the claim to manual review. The result is a mechanism that imposes administrative costs on the surgeon and returns essentially nothing, which is reflected in how rarely it is used. G2211, by contrast, is reported based on the billing practitioner's assessment of the visit and is paid without comparable documentation or review requirement.

If CMS retains a visit complexity adjustment in any form, whether as the existing G-code or as MOD1 and MOD2, the documentation and review standards applied to procedural complexity should be aligned with those applied to E/M complexity. At a minimum, MOD1 and MOD2 should be subject to the same documentation requirements that apply to Modifier 22. Further, there should be a mechanism for beneficiaries to be made aware of the fact that they are cost-sharing for increased services and that there is no mechanism in place for them to contest such an additional cost.

Alternatively, and in ACS' view preferably, CMS should eliminate the documentation and manual review burden associated with Modifier 22. The program should not maintain two mechanisms addressing the same underlying concept, one of which is readily usable and one of which is not.

ACS urges CMS not to finalize MOD1 or MOD2 without: (1) reconciling actual G2211 utilization with the assumptions underlying the policy; (2) explaining the resource basis for a percentage-based payment; and (3) publishing the distributional and budget-neutrality effects of the proposed transition, including its effect on beneficiary coinsurance across E/M levels.

ACS further urges that, if CMS retains any E/M visit complexity adjustment, it should apply documentation and review standards for reporting either G2211 or modifiers that are at least as rigorous as those imposed for reporting modifier 22. Alternatively, if no documentation and review is required for G2211 or modifiers, then the same standard should apply to modifier 22, and a comparable percentage increase should be applied automatically when modifier 22 is appended to a procedure code. Unusually intensive procedural work should be recognized on the same terms as unusually complex E/M work.

[18] Childers CP, Manisundaram NV, Hu CY, Chang GJ. Modifier 22 use in fee-for-service Medicare. *JAMA Surg*. 2024;159(5):563-569.

Proposed Changes to Payments using Modifier 25

CMS is proposing to reduce payment when a separately identifiable office or other outpatient E/M service currently identified on a claim by an appended modifier 25 is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, or 90-day global procedure. Under this proposal, the most expensive service (either surgical or E/M visit) would be paid at 100 percent, and all other surgical procedure(s) or E/M visit(s) would be paid at 50 percent. CMS asks for comments on the value of this adjustment, including whether it should be a different value, such as 25 percent. CMS also seeks comment on whether this policy should apply to other categories of E/M visits.

We highlight that modifier 25 may be appended to an E/M visit code to identify a distinct separately identifiable service when performed on the same day by the same physician as a "minor" procedure with a 0- or 10-day global period. For codes with a 90-day global assignment, an E/M that resulted in the decision for surgery on the day before or the day of the procedure is separately reported by appending modifier 57 to the E/M code.

Prior Rulemaking and Policy

This is the third time CMS has considered whether same-day E/M services and procedures contain duplicative resources. Each time, the Agency has treated the frequency with which a procedure and an E/M service are reported together as an indication that the resources represented by those services overlap. CMS' own prior rulemaking distinguishes the two.

Since the inception of the PFS, CMS has provided examples of when a separately identifiable E/M service is distinct and may be separately reported. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is performed for a patient with head trauma.[19]

In CY 2017, CMS used frequent reporting of 0-day global procedures with modifier 25 as a screen to identify services for further review as potentially misvalued, and the codes flagged through that screen were reviewed and revalued. The reporting frequency prompted examination. It did not establish that a fixed percentage of physician work or practice expense was duplicative.

In CY 2019, CMS proposed a related 50-percent multiple procedure payment reduction, reasoning that efficiencies associated with furnishing an E/M visit and a same-day procedure were sufficiently similar to those underlying the surgical multiple procedure payment reduction. CMS did not finalize that proposal after commenters submitted substantial information demonstrating that no such overlap existed.

Now, the CY 2027 proposal advances the same theory a third time and applies it more broadly, adding 10-day global codes reported with an office or other outpatient E/M service with modifier 25 appended. It does not supply the evidence that was missing in CY 2019.

[19] Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual. Chapter 12: Physicians/Nonphysician Practitioners, Minor Surgeries and Endoscopies.

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50-Percent Reduction Is Not Supported

The valuation history of surgical services demonstrates that potential same day E/M overlap has not simply been ignored in establishing current PFS values. Prior valuations of many procedures have expressly accounted for overlap with separately reported E/M services through adjustments to physician time and practice expense. CMS has also made adjustments to time and values when it was determined that particular resources were duplicative. A review of the CMS time file shows 0-day global codes with no preservice evaluation time and codes with less than 5 minutes total preservice (evaluation, positioning, scrub, dress, wait) time. These examples demonstrate the broader methodological problem with presuming that current surgical values uniformly contain an additional 50 percent of unrecognized duplication.

CMS characterizes additional overlap between separately identifiable E/M services and global procedures as likely. That characterization does not establish that residual duplication exists in current PFS values, much less that it equals 50 percent. Even where some efficiency may exist in furnishing services on the same day, CMS must distinguish between efficiency in a particular aspect of a service and duplication of one-half of the entire lower-valued service.

The proposed reduction applies at the payment level across physician work, practice expense, and professional liability components. CMS has not demonstrated that overlap exists across each of these components nor that the amount of any overlap is consistent across different E/M levels and 0- and 10-day global procedures. Before adopting a payment adjustment of this magnitude, CMS should demonstrate that the duplication it asserts actually exists in current PFS values, account for overlap already reflected in those values, and explain how the evidence supports the amount of the proposed reduction.

ACS urges CMS not to finalize the proposed 50-percent payment reduction as outlined in the Rule. Further, we do not agree that any reduction, even 10 or 25 percent, is appropriate. The Agency has not demonstrated that current 0- and 10-day global codes systematically contain duplication of work, practice expense, and malpractice expense every time a procedure code is reported with an E/M code with modifier 25 appended. An assertion that overlap is "likely" cannot support a payment reduction of this magnitude.

If CMS proceeds with consideration of a same-day payment adjustment, CMS should not apply a reduction without first demonstrating what physician work and/or practice expense remains duplicated after accounting for existing valuation adjustments and how the evidence supports why the service is not distinct.

CMS should also look at multiple cognitive services provided on the same day by the same provider to determine if those code pairs also have duplicative work. A recent ACS analysis of nearly 220 million office encounters reported with codes 99202-99205 and 99212-99215 found that the largest spending in terms of overlapping services in the PFS is on services with XXX global assignment. The most common and outsize impact codes were G0438 and G0439 (annual wellness visit) where 41 percent of claims for these codes include one additional code and over 20 percent of claims included two or more additional

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codes. In fact, in 2024, code 99214 was reported 37 percent of the time with G0439 which would imply that physicians spent 94 minutes per patient during a subsequent annual wellness visit (physician time for G0439 plus 99214) in addition to over 100 minutes of clinical staff time spent for these same two codes, all on the day of the service.

Potentially Misvalued Services Under the PFS

- **Request for Revaluation of Physician Work Time Based on Empiric Data (CPT codes 15734, 19318, 19380, 23472, 27130, 27447, 37227, 37229, 43281, 43644, 47120, 88305, 88307)**

ACS does not believe the information submitted by the MHCC provides an adequate basis either to revise physician time or work RVUs for the identified services nor to conclude that those services are potentially misvalued. CMS has not made such a determination in the proposed rule; rather, the Agency is seeking comment on the nomination and on whether any action should be considered for CY 2027 or future rulemaking.

The methodology raises significant questions. The submission relies on claims-based calculations that sum the PFS-assigned times across services billed on the same date for the same NPI number. The available analysis does not describe how multiple procedures, modifiers, team-based care, delayed or clustered billing, or other circumstances affecting claims were addressed. More fundamentally, identifying practitioner days on which the sum of assigned PFS times produces an implausibly long workday does not establish that the typical physician time assigned to an individual service is inaccurate.

CPT 47120 illustrates the problem. The nomination reports practitioner-day outliers for partial hepatectomy that, when translated using existing PFS time assumptions, imply a volume of major open liver operations within a single day that is not clinically plausible. An implausible result produced by summing assigned times across claims may demonstrate a limitation in the analytic method or underlying claims assumptions; it does not establish the typical time required to perform a partial hepatectomy. Valuation under the PFS is based on the typical service, not anomalous practitioner-day outliers.

The same concern applies to other general surgery services identified in the nomination, including CPT codes 15734, 43281, and 43644. Claims data and other empirical information can be useful in identifying questions for further examination, but they must be clinically interpretable and methodologically validated before they are used to alter physician time or work RVUs.

If CMS intends to develop a claims-based methodology for screening potentially misvalued services, the methodology should be transparent, validated, subject to public comment, and capable of being applied consistently across the PFS rather than selectively to a small group of services. **ACS urges CMS not to revise physician time or work RVUs for these services based on the MHCC nomination and not to conclude, based on these data, that the identified services are potentially misvalued.**

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RFI: REDESIGNING PRIMARY CARE TO MAKE AMERICA HEALTHY AGAIN

ACS supports strong, appropriately resourced primary care and recognizes the importance of prevention, longitudinal management, and coordination for Medicare beneficiaries. The College is concerned, however, about approaches that would increase relative primary care payment through further redistribution from surgical and other specialty services under a budget-neutral PFS. CMS specifically seeks comment on reconsidering relative primary care payment, technology-enabled primary care, and prospective primary care payment.

The premise that primary care can be strengthened only by reducing the relative value of specialty care should be rejected. ACS surgeon leaders recently reviewed the evidence underlying proposals to shift PFS resources toward primary care and concluded that policymakers should first evaluate the cumulative effects of changes already made to the fee schedule. Primary care is essential, but Medicare beneficiaries also require timely access to surgeons and other specialists for cancer, cardiovascular disease, trauma, complex gastrointestinal disease, neurologic disease, and other conditions for which specialty intervention can be definitive or lifesaving.[20]

ACS therefore urges CMS to avoid financing new primary care initiatives through generalized reductions to surgical work, global surgical services, or practice expense. Surgical and specialty care are essential components of the health care system, and their valuation should not be diminished to subsidize other priorities. If CMS believes additional investment in primary care is warranted, the Agency should identify the resources being furnished, value those resources transparently, and publish the resulting distributional effects. As discussed above, ACS urges CMS to support a permanent annual update to the fee schedule so that investment in one part of the health care system does not require repeated devaluation of another.

CPT RFI

ACS appreciates the opportunity to comment on CMS's questions regarding the CPT coding system and the CPT and RUC processes.

- ***What, if any, evidence is there that the generation of CPT-4 codes follows a process of identification of medical necessity?***

It is our opinion that CPT-4 describes procedures and services that are performed in humans to allow effective communication between health care providers. CPT has evolved over time to respond to the need for different "categories" of codes based on the level of evidence and need for quality measurement. There is no coding system (i.e., ICD-10, HCPCS, CPT) that requires medical necessity to establish a newly described service. "Medical necessity" is a payer and patient prerogative, not a coding system requirement.

[20] Childers CP, Senkowski CK, Selzer DJ, et al. Modernizing the Medicare physician fee schedule: what problem are we trying to solve? *Health Aff Forefront*. May 8, 2026.

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- ***Which if any alternatives exist to CPT–4 for CMS to consider as part of the national coding standard for physician services?***

We urge CMS to carefully consider the implications of replacing the current CPT coding system. At present, there does not appear to be another established coding system ready to serve as an alternative to CPT as the national standard for reporting physician and other professional services. Other coding and terminology systems (e.g., ICD-10-PCS, MS-DRG, APC) have important functions, but they serve different purposes and are not readily interchangeable with CPT.

Any consideration of a fundamentally different coding framework also needs to account for the practical consequences of transitioning from the current system to a new one. CPT is embedded throughout Medicare and private payer payment systems, physician practices, health information technology, contracts, quality measurement, and other healthcare infrastructure. Moving away from this framework before a replacement has been fully developed, tested, and shown to be operational could create substantial disruption for physicians, payers, and patients. Coding innovation should be encouraged, but a transition of this magnitude needs to be deliberate and carefully planned.

- ***What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?***

The CPT process allows for innovation, even while the innovation is still evolving, through CPT Category III codes, and more recently by investigating the establishment of value-based coding solutions. The RUC process itself does not inhibit innovation, as RUC recommendations work within the confines of a fixed relative value system for physician work (i.e., there is no component of the PFS for an extra "innovation" payment).

We believe, however, that practicing physicians must remain central to these processes. Determining whether services are clinically distinct and whether they meet the clinical criteria for a Category I code or are more appropriately identified through the Category III pathway requires meaningful input from practicing physicians with direct knowledge of the services and their clinical application. Economists, policymakers, data scientists, and emerging technologies, including artificial intelligence, can provide important information and tools to support this work. They cannot, however, replace the experience and judgment of physicians and practitioners who actually furnish the services being described.

ACS' own research provides an example of how objective data and practicing physician expertise can work together. An ACS led analysis of more than 110,000 adult and pediatric appendectomies used national clinical data to identify patient and procedural characteristics associated with materially different surgeon work, including complicated disease, operative approach, age extremes, interval appendectomy, and tumor. That work supported development of a more clinically specific appendectomy code structure.[21] The study illustrates the value of empirical information when it is

[21] 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. 2025*;160(10):1076-1081.

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interpreted in its clinical context and used to improve, rather than mechanically replace, physician led coding and valuation.

Transparency is an important part of these ongoing improvements, but it also needs to be balanced against legitimate confidentiality concerns. Materials considered during the code development process and associated valuation process may include information about emerging technologies, regulatory submissions, or other proprietary information that is not yet public. Premature disclosure of this information could provide a competitive or market advantage unrelated to the merits of a coding or valuation decision. We support continued efforts to make the code development and valuation processes, recommendations, and supporting information more accessible when appropriate, while retaining confidentiality protections where there is a legitimate need for them. Recent steps to make information available earlier in the process are constructive and demonstrate that increased transparency and appropriate confidentiality protections do not have to be mutually exclusive.

The need for continued evolution within CPT is also illustrated by services that do not yet correspond neatly to an existing code descriptor. ACS surgeon leaders, including Charles D. Mabry, MD, FACS; Dr. Childers; Dr. Selzer; and Christopher K. Senkowski, MD, FACS, have described the practical valuation challenges created by unlisted CPT codes and the importance of developing clinically appropriate pathways for recognizing physician work when established codes do not adequately describe a service.[22] This is an argument for a responsive and modernized CPT process, not for abandoning the national coding infrastructure before a viable alternative exists.

For these reasons, we generally support continued use and improvement of the existing CPT process. We encourage CMS, along with the AMA, practicing physicians, and other stakeholders to continue identifying areas where these processes can be improved. Modernization should include better use of objective data and new technologies and continued progress toward greater transparency. At the same time, it should preserve meaningful practicing physician involvement and avoid creating a disruptive transition before a viable alternative is available.

Conclusion

ACS appreciates CMS' consideration of these comments. Medicare payment policy should support access to the full continuum of care and should not rely on generalized assumptions that disproportionately devalue surgical and procedural services. ACS urges CMS to evaluate the proposals discussed above using transparent, service-specific clinical and empirical evidence and to consider their cumulative effects across surgical specialties.

These policies also have workforce implications. ACS has emphasized that payment instability, administrative burden, and other practice pressures contribute to surgical workforce challenges, particularly in rural and resource-limited communities. Medicare payment policy should support the

[22] Mabry CD, et al. Get credit for unlisted CPT codes: compliant approaches to wRVU valuation. ACS Bull. March 4, 2026.

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ability of surgeons and surgical practices to remain available where beneficiaries need them rather than create additional incentives for consolidation or withdrawal from underserved areas.[23]

MEDICARE SHARED SAVINGS PROGRAM

RFI: Specialty Care in the Shared Savings Program

ACS appreciates CMS seeking input on how the SSP can better incorporate specialists into accountable care. The RFI correctly recognizes that the SSP was built primarily around primary care assignment and population-level accountability even though specialists make up a substantial share of participating physicians and influence a large portion of Medicare spending. CMS also appropriately asks whether lessons from Innovation Center models, including the LEAD Model and CARA, could inform future SSP policy.

In summary, ACS recommends the following, discussed in more detail below:

- **Use the CARA architecture as a foundation but expand flexibility.** ACOs should retain population-level and total-cost-of-care accountability while specialty teams can voluntarily assume responsibility for defined episodes or conditions through arrangements tailored to the participants needs and resources. Participating clinical teams and ACOs should have broad discretion in choosing measures and episodes, rather than being required to default to existing individual-clinician quality and cost measures designed for other purposes; the specific flexibility needed for cost and quality measures is discussed below.

- **Standardize episode-based cost measure definitions.** CMS should continue to support common, clinically valid episode cost definitions developed transparently with specialty society input—for attributing cost and resource use. The current EBCMs are designed for individual clinician-level MIPS cost measurement and are therefore too narrowly defined to provide the information needed for specialty team engagement within an ACO. Flexibility should focus on care delivery, incentives, quality, and operating arrangements rather than proliferating incompatible cost episode definitions that undermine comparability and increase administrative burden.

- **Standardize the rails, not the clinical solution.** CMS should provide standardized episode and cost-measure definitions, data, contracting tools, reconciliation functions, guardrails, and structured options for shared incentives, while allowing ACOs and specialty teams to determine how to organize care and share accountability.

- **Permit flexible episode-specific quality frameworks.** The ACO is already accountable for population-level quality requirements. Specialty arrangements should instead be held

[23] American College of Surgeons. Advancing surgical care in underserved and rural communities. May 6, 2026. See also American College of Surgeons. ACS calls on Congress to take immediate action to address rising health care costs. March 2026.

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accountable for measures that are clinically meaningful and directly relevant to the specialty episode, including clinical outcomes, patient-reported outcomes (PROs), programmatic measures, and other episode-relevant measures. This approach would create more meaningful accountability while avoiding duplicative measurement and unnecessary reporting burden.

- **Align episode accountability and incentives with the specialty teams that can improve care.** CMS, through CARA, should ensure that episode responsibility is attributed to the clinicians and teams that meaningfully influence cost and quality, and that those teams receive timely data, authority to redesign care, and a transparent connection between improved performance and financial or non-financial support. Beyond the shared-incentive infrastructure CMS provides as part of standardizing the rails, CMS should allow ACOs and specialty teams broad flexibility in how those incentives are actually distributed among the responsible teams.
- **Protect patient choice and access.** Specialty accountability must not create closed networks, discourage care for complex or emergent patients, or pressure clinicians to select a site of care based on payment rather than clinical need and patient preference.

The College maintains that the general LEAD/CARA architecture is an appropriate starting point for specialist participation in accountable care. CARA recognizes that an ACO can retain responsibility for the overall health and total cost of care for its population while entering into episode-based risk arrangements with specialists and specialty organizations to improve care quality and efficiency for complex patients. This is consistent with prior ACS recommendations that CMS create an environment that allows meaningful contracting between ACOs and specialists around clinically valid episodes of care.[24]

However, even the CARA Maximal Flexibility (Max Flex) option remains too prescriptive to support the full range of specialty arrangements that ACOs and specialty care teams may need to develop. Under current LEAD specifications, Max Flex provides substantial modification to the construction of an eligible episode, including through an alternative episode grouper methodology, *but* arrangements remain limited to eligible CMS episode types and must use the *Clinician Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions* (Q484)[25] or another CMS-approved MIPS-comparable quality measure. CMS should build on CARA by creating a more flexible environment in which the Agency provides the infrastructure for specialty arrangements without prescribing the clinical operating model for each specialty, condition, community, or ACO.[26] For example, ACOs and specialty societies should be able to propose and enter into agreements that take accountability for episodes outside the scope of current CMS episode-based care models and utilize

[24] CMS, Medicare Shared Savings Program Guidance and Specifications. ACOs must meet a quality performance standard to receive maximum shared savings; CMS conducts compliance and quality monitoring and retains authority to take remedial action or terminate participation for specified failures. Beneficiaries remain in Original Medicare and retain freedom of choice.

[25] Partnership for Quality Measurement. Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System (CBE ID 3597). Accessed September 9, 2026. https://www.p4qm.org/measures/3597

[26] See, for example, ACS comments on the CY 2023 and CY 2024 Medicare Physician Fee Schedule proposed rules and ACS response to the Senate Finance Committee chronic care and Medicare payment RFI (2024), supporting clinically coherent specialty episodes nested within broader population-based accountability.

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quality frameworks built on clinically relevant specialty outcomes and PROs drawing on clinical data registries, verification and accreditation programs, or other innovative approaches.

CMS should look beyond just making specialists financially accountable inside an ACO. Instead, CMS should also consider whether a beneficiary reached the right specialty team, at the right time, with the right capabilities needed for that patient's condition and level of risk. Payment policy cannot create value if it rewards an arrangement that does not first support appropriate clinical decision-making and timely access to specialty care. These constraints may unnecessarily restrict innovation without providing corresponding benefits for patient safety or program integrity. CMS could continue to review proposed arrangements through the 4i platform[27] for clinical appropriateness and operational feasibility, but that review should function as a safeguard rather than as a mechanism for requiring conformity with existing CMS episode or quality frameworks.

CMS should continue to support common, clinically valid, patient-centered episode definitions and transparent grouper logic developed with specialty society and other stakeholder input. Standard episode definitions are essential to permit meaningful comparisons across providers, ACOs, delivery systems, and payers—ACS has consistently supported this approach. These standardized definitions should serve as common infrastructure and useful defaults, rather than as the exclusive episodes available to ACOs and specialty teams. Once the episode is defined, however, ACOs and specialty teams should have broad flexibility to determine how the care pathway is organized, how responsibility is shared, how incentives flow, which episode-relevant quality measures are used, and how the arrangement is adapted to local resources and patient needs.[28]

CMS should view its role as establishing the infrastructure and safeguards that allow these relationships to develop. **The Agency should provide standardized episode definitions, claims and benchmark data, contracting templates, reconciliation infrastructure, safeguards against duplicate payment, and structured options for shared incentives. The ACO and specialty care team should then determine the clinical and operational structure that can work in their environment.**

Within the CARA Max Flex framework, ACS believes ACOs and specialty care teams should have broad discretion to enter into arrangements they jointly determine will best serve patients and improve care, provided those arrangements protect beneficiaries and generate meaningful, actionable information on quality and cost. Existing CMS episode definitions, quality measures, payment methodologies, and other program constructs should be available as starting points, not mandatory design requirements. Where an alternative approach is clinically sound, operationally feasible, and capable of helping patients and referring clinicians identify high-quality care while fueling continuous improvement, CMS should permit its use.

[27] Centers for Medicare & Medicaid Services. CMS Innovation Center. Accessed September 9, 2026. https://4innovation.cms.gov/

[28] American College of Surgeons, FY 2027 IPPS Proposed Rule Comment Letter, June 9, 2026. ACS recommended that episode-based payment be paired with meaningful quality measurement, including episode-specific outcomes, patient-reported outcomes, adverse-event avoidance, and verification of care.

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This approach would allow smaller, physician-led ACOs to create arrangements with independent specialists without requiring ownership integration, while allowing high-revenue or health-system ACOs to create internal specialty service-line arrangements that make accountability and incentives clear and understandable to the clinicians responsible for care.

Quality policy should follow the same principle. As already noted, the SSP already holds the ACO accountable for quality and total cost of care for its population, through a quality performance standard, CMS monitoring, and beneficiary protections. These protections do not eliminate the need for meaningful specialty quality information, but they reduce the need for CMS to impose a second, rigid specialty measurement system inside each ACO. **Within a standardized episode, ACOs and specialty teams should be permitted to choose or create their own quality measures that are clinically relevant to the episode, matter to patients and referring physicians, and capable of identifying opportunities for improvement. CMS should make sure these measures do not allow providers to cut costs by compromising necessary care, but should not force them to follow the MIPS or MVPs formats. Specialty societies, patients, and other clinical stakeholders should play a lead role in developing and maintaining these measures.**[29]

For surgery, this flexibility is particularly important because surgical practice is generally episodic, while many medical specialties manage chronic conditions longitudinally. Procedural and longitudinal specialists should not be forced into a single accountability structure. The College has repeatedly recommended that payment and quality models reflect the clinical unit of care and that cost and quality be assessed together across a patient-centered episode.[30]

Below are responses to specific questions in the various sections of the RFI in line with the above recommendations.

Meaningful Engagement

- ***CMS seeks information on which aspects of SSP design most influence specialists' ability and willingness to participate meaningfully in accountable care, including data access, attribution, financial incentives, and clinical autonomy.***

Meaningful engagement requires more than including a specialist on an ACO participant list. In many settings, particularly when surgeons are employed by or contract with a health system, the individual clinician does not decide whether the organization enters an ACO, how attribution is structured, whether the specialist receives performance data, or how shared savings and losses are distributed. A clinician may therefore technically participate in an ACO without knowing which patients or services are

[29] CMS, Medicare Shared Savings Program Guidance and Specifications. ACOs must meet a quality performance standard to receive maximum shared savings; CMS conducts compliance and quality monitoring and retains authority to take remedial action or terminate participation for specified failures. Beneficiaries remain in Original Medicare and retain freedom of choice.

[30] See, for example, ACS comments on the CY 2023 and CY 2024 Medicare Physician Fee Schedule proposed rules and ACS response to the Senate Finance Committee chronic care and Medicare payment RFI (2024), supporting clinically coherent specialty episodes nested within broader population-based accountability.

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attributed to the organization and without receiving information or incentives that would change care delivery. In some cases, clinicians may not even be aware that they are participating in an ACO.

The SSP should encourage ACOs to create operating models that make specialty accountability visible and actionable. CMS should also ensure its gainsharing waivers are workable in practice and should consider additional flexibilities or expectations that would encourage ACOs, particularly hospital-led ACOs, to pass an appropriate share of savings through to the specialists whose care influences the success of the model. Specialists should know which patients and episodes are attributed to their team, understand the quality and cost goals associated with those episodes, receive timely feedback, participate in governance or care redesign decisions relevant to their service line, and understand how improved performance will affect the team. Additionally, removing requirements that MIPS-comparable quality measures must be used creates opportunities for meaningful quality measurement. For example, programmatic quality frameworks that assess how a care team achieves the structures, processes, and outcomes needed for high-quality care across a service line should be explored.[31] Such approaches could also deliver information in more useful ways, such as a real-time dashboard, rather than waiting for payment incentives two years later based on traditional measures. This is fundamentally both a clinical design and a business-model issue.

Specialist engagement will be strongest when the unit of accountability corresponds to a clinical decision the specialist actually makes. For procedural specialists, that unit is generally a defined episode with a beginning, a clinically appropriate scope, and an end. For specialists who manage chronic conditions longitudinally, accountability may instead need to be organized around the condition and the patient population under their care. **CMS should allow these approaches to coexist and, where appropriate, nest procedural episodes within broader condition-based accountability.** The ACS-Brandeis Advanced APM proposal[32] contemplated this structure by combining procedural and chronic condition episodes and assigning responsibility according to each clinician's role in the patient's care. EGM methodology, also demonstrate that longitudinal condition accountability and acute or procedural episodes can be analyzed within a common framework that appropriately allocates overlapping services and avoids double counting costs.[33] **Building on that approach, CMS could explicitly permit voluntary condition-based arrangements for specialists who function as principal longitudinal clinicians, while preserving the ACO's overarching accountability for the beneficiary's total cost and quality of care.**

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[31] 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.

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

[33] Centers for Medicare & Medicaid Services. Method A: Episode Grouper for Medicare (EGM) Design Report. February 29, 2016. Accessed September 9, 2026. 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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- ***CMS seeks information on how the SSP could better support care delivery interventions such as e-consults and co-management models, and whether other interventions should be considered.***

ACS supports e-consults, co-management, perioperative optimization, shared decision-making, care-transition programs, and other interventions when they improve patient care. We urge CMS to maintain flexibility to allow ACOs to select interventions based on local specialist availability, practice structure, patient needs, and existing clinical infrastructure. The appropriate intervention for a rural ACO working with a distant tertiary surgical program will differ from the intervention available within an integrated academic health system.

CMS can best support these interventions by reducing barriers to contracting, providing timely data, allowing flexible payment arrangements, and ensuring that existing billing or model rules do not penalize clinically appropriate co-management. **Where a discrete service requires separate payment to make the intervention viable, CMS should make that option available without requiring the entire specialty relationship to be built around a billing code.**

- ***CMS seeks information on which financial, quality-based, or operational incentives most effectively drive adoption of value-based care interventions, including care coordination codes, QP-related MIPS exemptions, and CARA-style sub-capitation or episode arrangements.***

For procedural specialty care, ACS finds that structured episode-based shared incentives are more likely to be meaningful than isolated care-management codes. CARA moves in the right direction because it allows ACOs and downstream specialists to share responsibility for a defined episode. CMS should expand this concept to SSP and allow ACOs to select from structured payment options, including shared savings, limited downside risk, prospective care-management support, and other arrangements, while preserving local flexibility regarding the exact distribution of incentives.

As previewed above, financial incentives should be contingent on meaningful quality performance so that lower spending alone does not define value. At the same time, the quality component should be designed around the episode, aggregated at the team or group level, rather than imported from unrelated MIPS requirements which use individual-level measurement. Non-financial incentives can also be substantial. As a result, **we urge CMS to explore providing specialists engaged in these arrangements with actionable data, reduced duplicative reporting, technical assistance, recognition of existing high-performing quality programs,[34] and real authority to redesign care.**

CMS could also consider using CARA as a pathway to voluntarily test and evaluate specialty care models developed by specialty societies and other stakeholders, including models previously recommended for testing by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). These models have proposed a range of approaches to aligning incentives for specialty care,

[34] Programs such as ACS's verification and accreditation programs [e.g., Trauma Verification, Review, and Consultation (VRC), Commission on Cancer (CoC), Geriatric Surgery Verification (GSV), Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSQIP)] evaluate whether a facility or care team has the risk-adjusted outcomes tracking, multidisciplinary staffing, resource availability, and care-coordination protocols associated with high-quality care.

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demonstrating that there is unlikely to be a single payment structure that is appropriate across specialties, conditions, and care settings. Rather than requiring CMS to establish a separate model for each approach, CARA could provide the infrastructure for ACOs and specialty care teams to voluntarily implement and evaluate different incentive arrangements within the broader accountability framework of the ACO. This would allow CMS to test multiple approaches to specialty engagement and identify those that are most effective at improving patient outcomes, quality, and efficiency.

To enable this testing, CMS should permit CARA participants to use clinically validated episode, payment, and quality methodologies developed outside of CMS, rather than requiring every arrangement to conform to existing CMS episode-based cost measures or MIPS-comparable quality measures. For the same reasons already noted regarding quality measures, ACS has long raised concerns that the current MIPS cost measures rely on a largely one-size-fits-all, claims-based methodology that limits clinically meaningful risk stratification, subgrouping, and episode specifications and does not adequately connect cost with quality, reducing their usefulness as actionable measures of specialty value. Existing EBCMs may therefore be sufficient for MIPS, but they are not appropriate to define the universe of episodes or methodologies available under CARA. CMS could establish appropriate parameters and monitoring requirements while allowing ACOs and specialty care teams flexibility to determine how accountability and incentives should operate within those parameters.

- ***CMS seeks information on differences in specialist engagement across low-revenue and high-revenue ACOs, including employed versus contracted specialists, and on strategies appropriate to different specialty types and high-need populations.***

ACS agrees that the resources and organizational structures of low- and high-revenue ACOs differ, but revenue status should not become a proxy for whether specialists are engaged. A low-revenue ACO may need standardized contracts, turnkey episode reports, and CMS-supported payment administration to work with independent specialists. A high-revenue ACO may have sophisticated analytics and employed specialists but still fail to create engagement if performance information and shared savings remain at the system level and the clinical team has no authority to redesign care.

The more relevant design question is whether the arrangement gives the specialty team a clinically coherent area of responsibility, meaningful data, and authority to act. As discussed above, procedural specialists should generally be engaged through episodes, while those who serve as chronic disease co-managers or principal longitudinal clinicians may require condition-specific longitudinal arrangements. For high-need patients, both types of specialists may need enhanced support for care coordination, medication management, functional assessment, social needs, and transitions across settings.

- ***CMS seeks information on how to preserve physician autonomy while advancing accountability for cost and quality.***

Accountability should align with the care decisions and outcomes a clinician can reasonably influence. The ACO can remain accountable for population-level total cost of care while a surgeon and multidisciplinary team accept focused responsibility for a defined episode. Within that episode, CMS should preserve clinical autonomy and patient choice, use risk adjustment that protects against

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incentives to avoid complex patients, and ensure that payment incentives do not reward withholding medically necessary care or selecting patients solely on the basis of financial risk.

CMS-Delivered Tools and Support

- ***CMS seeks information on how ACOs use shadow bundle data, why some ACOs do not use these data, and which data or tools would provide meaningful feedback to specialists.***

ACS supports CMS continuing to provide standardized episode-level data. Shadow bundles are directionally consistent with the College's longstanding support for standard episode definitions because they can give ACOs and specialists a common unit for understanding cost and utilization. However, the data will not drive care redesign if they remain retrospective claims profiles that cannot distinguish clinically different patients or identify why a particular cost was incurred.

CMS should make episode information more actionable by incorporating important clinical distinctions that affect expected outcomes and resource use. This should include distinguishing elective from urgent or emergent care where clinically relevant and incorporating functional status, frailty, and other important clinical risk factors when those data can be obtained and reliably validated. Claims data should be paired, where feasible, with clinical registry data, patient-reported information, and validated risk adjustment so that appropriate high-acuity care is not mislabeled as inefficiency.

The timing and delivery point of information also matters. Data intended to influence referrals or care planning should be available as close as possible to the point of clinical decision-making, not only through year-end reconciliation files. Commercial claims-integration and analytics platforms already demonstrate that this is technically feasible: aggregating linked claims and clinical data across large patient populations into near-real-time dashboards, using predictive analytics to flag emerging utilization and risk patterns well before annual settlement. CMS should encourage—rather than structurally discourage through delayed data release schedules—ACOs' and specialty groups' adoption of comparable prospective analytics capabilities, whether built in-house, licensed from vendors, or provided through CMS's own claims data feeds. At a minimum, CMS-supplied performance data should be structured to support the same granularity these commercial platforms already offer: viewable at the patient, episode, specialty group, service-line, facility, and ACO levels, and updated on a cadence that allows course correction during the performance period rather than only retrospective accounting after it closes.

- ***CMS seeks information on how specialty data could better support high-value referrals based on outcomes, complications, and efficient use of resources.***

Referral information should present data on value, not cost alone. A profile that simply ranks specialists by Medicare spending could discourage appropriate referrals to trauma centers, rural referral centers, safety-net providers, or programs caring for more complex patients. Useful information for patients and referring physicians should combine risk-adjusted clinical outcomes, major complications, PROs and recovery, appropriate utilization, episode cost, access, and relevant information about the capabilities of the care team.

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Claims data cannot reliably capture whether an individual referral was appropriate—that judgement depends on clinical context and institutional capability that claims do not reflect. **Rather than constructing a claims-based referral score, CMS should consider evaluating the structures and processes a care team uses to make referrals and co-management decisions.** Established specialty-specific quality and verification programs already provide a model for this approach. Programs such as ACS's verification and accreditation programs (e.g., verification standards for trauma, cancer, geriatric surgery, and bariatric surgery) evaluate whether a facility or care team has the risk-adjusted outcomes tracking, multidisciplinary staffing, resource availability, and care-coordination protocols associated with high-quality care. These structural and process measures are particularly well suited to complex or high-acuity referrals, where the appropriateness of a given case often depends on institutional capability (e.g., trauma level designation, Intensive Care Unit (ICU) capacity, subspecialty coverage). **CMS should consider recognizing verified or accredited program status, or the underlying structural and process standards those programs already require, as a valid input for referral-support tools, rather than developing a parallel claims-based framework that would not capture these dimensions of care team capability.**

- ***CMS seeks information on how CMS-delivered tools should differ for low-revenue and high-revenue ACOs and what additional resources could support specialty integration.***

CMS should provide the same core episode definitions and data to all ACOs, but the form of support should vary. Consistent with the point above regarding low- and high-revenue ACOs, smaller and physician-led ACOs need turnkey dashboards, simple contracting templates, and technical assistance that do not require large analytics teams, while larger systems may prefer standardized data feeds and more configurable tools. CMS should avoid designing a product that is useful only to organizations that already possess extensive analytic infrastructure.

Attribution and Assignment Modifications

- ***CMS seeks information on whether and how specialists should be incorporated into beneficiary assignment while maintaining strong primary care relationships.***

For procedural specialists, ACS does not recommend replacing the SSP's primary-care-based beneficiary assignment with specialty assignment. The beneficiary should remain assigned to the ACO through the existing population framework. CMS should instead layer episode-specific accountability over that assignment so that a surgical or specialty episode can be attributed to the appropriate specialty team without moving the beneficiary out of the primary care relationship, which ideally should continue through and beyond the episodic treatment.

A specialty episode should have a clinically defined entry point, a bounded scope, a defined terminus, and an explicit handoff back to longitudinal care when appropriate. This creates a clear object of shared accountability while preserving the ACO's role in the beneficiary's broader care.

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The ACS has previously proposed one option for attribution in an episodic payment model as part of its ACS-Brandeis Advanced APM proposal.[35] Under that model, the EGM identified the clinicians participating in a defined episode of care and attributed responsibility based on each clinician's relationship to the patient and role in the episode. This attribution approach drew in part on CMS's early MACRA proposal for patient relationship categories. Clinicians participating in the episode could then be automatically organized into clinical affinity groups, allowing accountability to be shared across the care team rather than assigned entirely to a single physician. This approach recognizes that different clinicians influence different portions of an episode while creating a common framework for measuring the cost and quality of care delivered by the team. PTAC recommended the ACS-Brandeis Advanced APM for limited-scale testing in 2017. An updated version of this model could be one option for attribution in specialty care episodes within ACOs that would create accountability without additional administrative burden.

- ***CMS seeks information on how assignment should account for NP/PA-delivered care and how the SSP should recognize specialists who serve as a beneficiary's principal longitudinal care provider.***

ACS recognizes that advanced practice providers play important roles on surgical and specialty teams. Attribution methodology should reflect team-based care and avoid assuming that every claim billed under a physician necessarily represents a discrete decision by that physician. **For specialties in which a specialist truly serves as the beneficiary's principal longitudinal clinician, CMS should consider condition-specific pathways that recognize that role without disrupting statutory primary care assignment requirements for the broader ACO population.**

- ***CMS seeks information on how specialists can share accountability for total cost and quality without serving as the primary clinician, and which design features could support shared accountability between primary care and specialists for specific conditions and episodes.***

The College recommends a nested model. The ACO retains accountability for total cost of care and longitudinal coordination. The specialty team assumes responsibility for the quality and cost of a defined episode or condition. Primary care can support optimization, medication management, and reconnection to longitudinal care; the specialist can direct the episode-specific clinical pathway; and the ACO can support transitions, post-acute coordination, data, and financial reconciliation.

Attribution should be role-based and should recognize that responsibility is shared across the surgeon, anesthesia professionals, hospital, rehabilitation providers, post-acute providers, and others. This role-based structure builds directly on the ACS-Brandeis/EGM model described above.[36] The purpose of attribution is to create a clinically meaningful team signal, not to imply that one physician controls every

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

[36] American College of Surgeons. Proposal for a Physician-Focused Payment Model: ACS-Brandeis Advanced Alternative Payment Model. December 13, 2016. https://aspe.hhs.gov/sites/default/files/private/pdf/255906/ACSReportSecretary.pdf. Pages 9-11.

service included in the episode. This approach also allows episode volume to be aggregated at the team or group level, reducing the statistical problems created by individual-clinician measurement.

Benchmarking

- ***CMS seeks information on approaches for developing specialty-specific cost benchmarks, including how to address low volume and high-cost variability.***

Specialty benchmarks should be constructed around standardized, clinically valid episodes or conditions. The College continues to support common episode definitions because the same clinical unit should be used to compare performance across ACOs and delivery systems. As recommended above, CMS should engage specialty societies and clinical experts in developing and maintaining the episode specifications and should make the underlying logic transparent.

Low-volume problems should be mitigated through appropriate aggregation and statistical methods rather than by forcing unreliable individual-clinician comparisons. Depending on the episode, CMS should consider measurement at the specialty group, multidisciplinary team, service-line, or facility level; pooling multiple performance periods where necessary; and using minimum case thresholds or reliability adjustment. The appropriate unit of accountability should reflect how care is actually delivered and allow responsibility to be shared among the clinicians and organizations that can meaningfully influence episode performance.

- ***CMS seeks information on how to define sub-populations for specialty benchmarking and which risk adjustment factors should be incorporated.***

Sub-populations should reflect clinically meaningful differences that affect expected resource use and outcomes. For surgery, relevant distinctions may include the procedure and diagnosis; elective versus urgent or emergent presentation; inpatient versus outpatient settings where appropriate; initial versus revision procedure; trauma or transfer status; procedure complexity; and whether major complications or other high-risk features were present before the episode began.

Risk adjustment should incorporate variables that predict legitimate differences in resource use and outcomes, including acuity, comorbidity burden, frailty and functional status, emergency status, procedure complexity, social risk, and geography when appropriate. CMS should distinguish pre-existing patient complexity from complications arising during the episode. Preventable complications should generally remain visible as quality and cost signals rather than being adjusted away.

CMS should consider testing a risk-capability concordance approach in which cost comparisons are stratified not only by patient risk but also by the clinical team's conformance to evidence-based standards demonstrated through participation in a recognized verification or accreditation program for the relevant service line or condition. Higher-capability programs tend to treat more complex patients whose care legitimately requires more resources—patient-level risk adjustment often does not fully capture that complexity. Stratifying cost comparisons by conformance to standards would compare teams against peers with similar clinical scope and align cost expectations with the acuity of the patients each program is designed to serve. This concept could help CMS determine whether

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apparently higher spending reflects inefficiency or the appropriate concentration of high-risk patients in programs equipped to manage them. Any such approach would require careful testing and should not replace conventional statistical reliability standards.

- ***CMS seeks information on how specialty-specific benchmarks should interact with the SSP total-cost-of-care benchmark.***

Episode spending should remain part of the ACO's total cost of care, and specialty benchmarks should be nested within rather than stacked on top of the ACO benchmark. CMS should prevent duplicate rewards or penalties for the same spending and should clearly specify how episode reconciliation interacts with the ACO's overall financial settlement. CMS should also provide transparent information on the specialist's performance within their episodes so that specialists can use the information for improvement purposes or potential future employer contracting. This is another area in which CARA provides a useful starting architecture: the specialty arrangement can create a meaningful internal financial signal while the ACO remains accountable for the population-level result.

Importantly, specialty arrangements should not be viewed simply as dividing or redirecting an ACO's existing shared savings. Meaningful specialty engagement creates an opportunity to improve care and generate additional value in an area that has historically received less attention within population-based, cost-containment efforts. By engaging specialty care teams in redesigning care, preventing complications, improving transitions and recovery, and reducing avoidable utilization, ACOs can improve outcomes for patients while also improving overall performance. Properly structured, specialty and ACO incentives should therefore be mutually reinforcing: better specialty care contributes to better population-level results, creating greater opportunity for the ACO and its participating clinicians to succeed together.

Specialty Performance Measures

- ***CMS seeks information on how specialist performance should be assessed within ACOs and whether specialty assessment should differ from current ACO-wide assessment.***

Consistent with ACS's recommendation above to permit flexible episode-specific quality frameworks, the SSP's population-level quality framework serves an important purpose but is not designed to provide a complete assessment of surgical or other specialty care; CMS should retain ACO-wide quality requirements while permitting a separate, flexible, episode-level framework for specialty arrangements. The specialty framework should measure the same patients and clinical episode used for cost accountability.

ACS recommends that specialty quality be designed as a program of care rather than a narrow list of isolated measures. For surgical episodes, the framework can include patient goals and PROs, avoidance of major adverse events, episode-relevant clinical outcomes, and recognition of the structures and processes necessary to deliver high-quality care. The College's verification and accreditation

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programs demonstrate how team-level standards, processes, outcomes, and continuous improvement can be combined to evaluate a service line in a clinically meaningful way.[37]

The College does not support requiring every specialty arrangement to use MIPS-comparable measures, as CARA currently contemplates. A MIPS-comparability requirement could inadvertently exclude measures or programmatic quality approaches that are more clinically useful for the episode. **CMS should instead establish a minimal standard: the selected quality framework must be relevant to the episode, aggregated at the team or group level, developed or endorsed with appropriate clinical and patient input, transparent to participants, and sufficient to ensure that financial savings are not achieved through lower-quality or medically inappropriate care.**

- ***CMS seeks information on specialty performance profiles, prevention and upstream management, and which quality information would help ACOs improve coordination, outcomes, and cost management.***

Quality information should help patients, referring clinicians, and care teams understand what happened during the course of patient care, and what can be improved. For procedural care, useful information includes risk-adjusted clinical outcomes, major complication avoidance, patient goals and recovery, shared decision-making, appropriate site of care, transitions, readmissions and emergency department use, and information about the care team's readiness to manage the relevant patient population.

Upstream management is also part of specialty value. Preoperative optimization, frailty assessment, nutrition, smoking cessation, diabetes management, medication review, prehabilitation, and shared decision-making can affect both outcomes and spending. Measures should therefore be capable of recognizing whether the system helped the patient reach an appropriate intervention in an optimized condition rather than focusing only on what occurred during the procedure itself.

The breadth of these factors illustrates why surgical quality is best assessed through a programmatic approach rather than a collection of isolated measures. High-quality surgical care depends on having the structures and processes in place to reliably deliver appropriate care across the episode and then assessing whether those systems produced the intended clinical and patient-centered outcomes. ACS refers to this approach as "programmatic measurement," which brings these elements together by evaluating the capabilities of the care team, the processes used to deliver care, and outcomes such as major complication avoidance, PROs, and achievement of patient goals.[38] This approach provides a more complete assessment of quality while also producing information that care teams can use to identify opportunities for improvement and that patients and referring clinicians can use to make informed care decisions.

As a potential expansion of the measure framework to include programmatic measurement, CMS could track conditions typically managed with elective surgery, analyzing how often patients

[37] American College of Surgeons, FY 2027 IPPS Proposed Rule Comment Letter, June 9, 2026. ACS recommended that episode-based payment be paired with meaningful quality measurement, including episode-specific outcomes, patient-reported outcomes, adverse-event avoidance, and verification of care.
[38] 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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instead require emergency surgery—adjusted to account for how sick patients already were at baseline. A high rate might signal that patients aren't getting the preventive care or follow-up they need before things become an emergency. **At the same time, Medicare could test a small set of related, guideline-anchored quality measures that flag gaps in care before attaching financial consequences. CMS could pilot this as pay-for-reporting. Such measures would need specialty-society validation, clear exclusions, monitoring for unintended risk selection, and a period of descriptive reporting before any scoring.**

- ***CMS seeks information on barriers and burden associated with specialist data collection, whether system-level measures could reduce burden, and how MVPs could be used to support specialist accountability.***

System-level and service-line measures can reduce burden and better reflect team-based care, but they should complement rather than obscure episode-level information. **ACS does not support using MVPs as the primary specialty quality solution inside ACOs. MVPs remain constrained by the MIPS architecture and statutory requirements and can still group clinically dissimilar services or measure individuals when the relevant unit of care is the team.**

Where a validated specialty quality or verification or accreditation program already evaluates the structures, processes, outcomes, and improvement activities of a service line, CMS should consider recognizing participation in that program as an alternative or streamlined pathway for some reporting requirements. This could reduce duplicative reporting while preserving clinically meaningful accountability. A substantial majority of SSP ACOs now participate in tracks which qualify as Advanced APMs, and clinicians who meet the applicable participation thresholds in these arrangements achieve QP status and are exempt from MIPS. **As CMS develops additional mechanisms for specialty accountability within the SSP, it should build on this principle and avoid layering duplicative MIPS or MVP requirements on specialists who are already meaningfully accountable for cost and quality through an ACO and specialty arrangement.**

<u>Waiver Flexibilities</u>

- ***CMS seeks information on which existing SSP waivers have supported specialty integration, how waivers could be expanded for specialist-driven pathways, and what additional waivers should be considered.***

ACS supports continued access to telehealth, the Skilled Nursing Facility (SNF) three-day rule, and the Acute Hospital Care at Home waivers where they enable clinically appropriate care. Telehealth can be particularly valuable for perioperative co-management, specialty consultation, and follow-up in rural and underserved areas. The Acute Hospital Care at Home waiver can support postoperative recovery and management of appropriately selected surgical patients in their home, avoiding the risks and costs of unnecessary inpatient days. CMS should examine specialty-specific barriers to existing waivers rather than assume that low uptake reflects a lack of clinical value.

CMS should also consider testing payment and coverage flexibilities for structured preoperative optimization and prehabilitation for high-risk surgical patients when those services are part of an

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evidence-based episode care plan. Although individual components of preoperative optimization may be covered under existing Medicare payment rules, current FFS payment mechanisms may not adequately support comprehensive, coordinated preoperative optimization programs. These programs have the potential to improve patients' readiness for surgery, prevent complications, and reduce avoidable utilization.

CMS should monitor whether ACO financial rules create a disincentive to refer a high-risk beneficiary to a specialty program outside of the ACO with capabilities better matched to the patient's needs. If this problem is demonstrated, CMS should test a narrowly designed referral flexibility or reconciliation adjustment that removes the financial penalty for clinically appropriate external referral while preserving beneficiary choice and program integrity.

When assessing new waiver authority, CMS should ensure that they are designed to better meet the needs of patients, not exempt systems from care that might be burdensome or costly but in their best interest. Smaller ACOs may need greater administrative support to use waivers, while larger systems may need flexibility to coordinate care across multiple sites of service. In all cases, CMS should preserve beneficiary freedom of choice and avoid creating financial incentives that function as closed networks.

ACO and Provider Burden

- ***CMS seeks information on how to reduce specialty quality-reporting burden while maintaining meaningful accountability, reduce data-sharing burden, and address requirements that disproportionately affect smaller or rural specialty practices.***

The most important burden principle is that CMS should not stack multiple accountability systems on the same episode. A surgeon should not have to satisfy duplicative MIPS, ACO, and specialty episode reporting requirements for the same clinical work. If a specialist is meaningfully accountable for an episode within an ACO, CMS should seek to align or waive duplicative requirements where statutory authority permits. Standard episode definitions can materially reduce burden because ACOs, specialists, patients, and payers can use the same clinical unit rather than translating among multiple proprietary groupers. This approach has the added benefit of aligning incentives for all involved in the care of the patient. **CMS should also allow use of specialty registries and established quality programs so that clinically meaningful data already being collected for improvement can satisfy federal reporting needs where appropriate**.

Established, high-quality surgical registries such as ACS's National Surgical Quality Improvement Program (NSQIP) already collect risk-adjusted, clinically validated outcomes data across more than 850 participating hospitals for ongoing quality improvement. ACS is also modernizing this infrastructure through a partnership with Epic: the resulting ACS Digital Registry will draw registry data directly from participating hospitals' electronic health records rather than relying solely on manual chart abstraction, further reducing the data-collection burden on specialty practices while improving the completeness and timeliness of the resulting data. Recognizing well-established and increasingly electronic health record (EHR)-integrated registries of this kind as a qualified reporting pathway would let CMS draw on a data

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infrastructure that already exists and is actively improving, rather than requiring specialists to build a new, parallel reporting stream.

Consistent with the point made above regarding low- and high-revenue ACOs, smaller and rural specialty practices should not be expected to build the same analytics infrastructure as large health systems. CMS should provide simplified data feeds, turnkey dashboards, standardized contract templates, and technical assistance. Participation for a clinician should not require ownership integration or employment by a health system. The CARA concept is particularly valuable in this regard because CMS can administer the data and payment functions that would otherwise create substantial barriers for independent practices.

A staged implementation approach can reduce both burden and unintended consequences—detailed in the Recommended Implementation Path below:

Recommended Specialty-Engagement Implementation Path

The College encourages CMS to use the SSP RFI and LEAD/CARA experience to create a durable specialty-engagement pathway and innovation partnership with specialty societies rather than another short-lived specialty model. The following sequence would allow CMS to learn while providing immediate value to ACOs and clinicians:

1. **Standardize the episode infrastructure.** Maintain a national library of clinically valid, patient-centered episode definitions and transparent grouper logic developed with specialty societies and other stakeholders.

2. **Improve visibility and data.** Partner with innovators to provide timely episode-level data with clinically meaningful risk information, including acuity and functional risk where feasible, and make the information usable at the point of care.

3. **Create a flexible contracting platform.** Use CARA-like CMS administration to support voluntary agreements between ACOs and specialty teams, but allow broad flexibility in care pathways, risk-sharing terms, internal distribution of incentives, and episode-specific quality frameworks.

4. **Measure before mandating.** New measures and accountability constructs should be reported descriptively and validated before they determine payment. CMS should use specialty society and patient input to identify which approaches provide meaningful information and avoid unintended consequences.

5. **Scale what works.** CMS should use evidence from SSP and CARA arrangements to identify durable options that can be adopted voluntarily across ACOs rather than imposing one national specialty operating model.

The ACS appreciates CMS's recognition that the next phase of accountable care must better incorporate specialists. The College finds that CMS has identified the right general direction in LEAD and CARA, but the opportunity is larger than a new CMS-defined episode program. The SSP can become a platform in which population-based accountability and specialty episode accountability reinforce one another,

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provided that CMS supplies consistent infrastructure while allowing ACOs and specialty care teams enough flexibility to build arrangements that work for their patients, clinical environments, and available resources.

The ACS welcomes the opportunity to work with CMS and the Innovation Center on the development of standard episode definitions, specialist quality frameworks, data tools, and flexible arrangements that can meaningfully engage surgeons and other specialists in accountable care.

AMBULATORY SPECIALTY MODEL

In the CY 2026 PFS, CMS finalized the implementation and testing of the ASM, a mandatory APM with five performance years (January 1, 2027 – December 31, 2031). CMS states that the goal of ASM is to enhance quality of care and reduce costs for Medicare beneficiaries with the chronic conditions of heart failure or low back pain. The model intends to 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 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 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.

The ACS continues to have major concerns with the design of ASM which we believe will greatly limit the success of the model:

- **Individual clinician-level participation.** The ASM is fundamentally flawed by focusing on measurement at the individual clinician level. This is contrary to how CMS and the Innovation Center should be thinking about care coordination and patient centricity, and it strays from the reality of current care delivery for patients with low-back pain or heart failure. For both conditions, effective care is inherently team-based, requiring coordination across multiple clinicians, specialties, and care settings rather than the efforts of a single practitioner. Additionally, measuring quality and cost at the individual clinician level will never achieve statistically reliable measurement because the volume of procedures needed to reliably show distinction are typically not achieved for specialty care at the individual level. By repeating this individual-level design, ASM risks the same credibility problem already seen in MIPS, where measure outputs do not meaningfully reflect how clinicians actually deliver care.

- **One-size-fits-all approach to measurement**. Specialty care varies according to the patient's risk factors (comorbidities), adherence to care, the degree and acuity of their condition, the complexity of care, and resource availability at the moment of care. Without regard for these adjustments, measurement fails as a one-size-fits-all approach. Instead, the ACS strongly supports models that evaluate quality and cost performance with appropriate levels of risk adjustment at the episode level that considers the full program of care. This would provide more

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accurate and meaningful evaluation of care delivered as part of the patient's care journey, rather than isolating performance at the individual physician level.

- **Reliance on 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 three key elements that reflect care: 1) the degree to which the team delivered on patient expectations (outcomes and goals of care); 2) overall safety of care based on the avoidance of selective major complications; and 3) verified facility conformance to episode standards, reflecting adherence to the structures and processes needed to support the care team.

- **Tournament-style model design.** By ranking participating clinicians against one another on relative cost and quality performance, the tournament-style model discourages collaboration and primarily incentivizes cutting costs—a race to the bottom. This methodology pits members of the team against each other rather than incentivizing the organization around the patient.

- **Overly narrow MIPS cost measure methodology.** The existing MIPS cost measures are very narrowly defined, limiting their value for incentivizing reduction in cost within MIPS/MVPs. The EBCM methodology used in MIPS measures lacks the ability to create actionable information that maps to the entirety of episodes of care. This approach does little to account for risk-adjusted differences in services or create reports that reflect services, times, and setting reports that inform care teams about cost drivers. Without this, the Acumen approach remains siloed and uninformative for corrective action.

Ultimately, if CMS seeks to inform and improve the value of care, the goal must be more than payment driven. **With these outstanding concerns, the ACS recommends CMS delay the implementation of this model and consider an overhaul of the ASM in terms of both the quality and cost metrics, and level of measurement, to better reflect the patient's experience of how the condition is treated. ACS urges CMS to engage stakeholders in a transparent and collaborative process to redesign this model.**

We respond to additional ASM proposals included in this proposed rule below.

Voluntary Data Submission for the Development of Patient-reported Outcome-based Performance Measures (PRO-PMs)

CMS discusses its interest in adopting a PRO-PM in ASM that evaluates changes in patient reported health status, physical function, symptoms, or related outcomes over time. To support this goal, the Agency proposes to establish a voluntary data submission opportunity and scoring incentive for ASM participants to report PRO data. Eligibility for the incentive would be limited to the ASM cohorts for the

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ASM performance years when they are actively developing a PRO-PM. This proposal is intended to assess evaluation of the feasibility, reliability, validity, and appropriateness of one or more future Patient-Reported Outcome Measurement Information System (PROMIS)-based or other PRO-based PRO-PMs before any measures are proposed for inclusion in an ASM cohort's quality measure set.

ACS supports this proposal and asks CMS to maintain flexibility in the PRO-PMs that qualify for the incentive going forward, as well as not limit the availability of this incentive to only the years that CMS is actively developing a PRO-PM. Measure frameworks built around PROs—including patient experience and patient goal attainment—are essential to patient-centric quality programs. PROs give patients a direct opportunity to assess whether their care team understood their goals and delivered goal-concordant care—in other words, whether the care ultimately addressed the reason the patient sought treatment in the first place. For the surgical team, understanding a patient's expectations and goals before an operation—and then receiving direct feedback afterward on goal attainment, experience, and physical function—is invaluable, not only to the team itself but to the patient, their caregivers, and referring physicians. Incentivizing ASM participants to implement and report PRO-PMs before they are tied to scoring offers a positive step towards increased PRO-PM reporting.

ASM participants should also be allowed to report the PRO-PMs most relevant to their own practices and patient populations. CMS has stated that its goal of incentivizing PRO-PM reporting is to collect data on which PRO-PMs are most useful for this model. Allowing participants to select their own PRO-PMs, rather than limiting them to a fixed list for incentive points would let CMS capture more meaningful data—signaling both priority areas and which PRO-PM tools practices can feasibly implement, maintain, and act on. For example, if a large share of ASM participants prioritize shared decision-making and use the CollaboRATE tool to capture patients' experience, that pattern would show CMS that this PRO-PM merits consideration for ASM, or other quality reporting programs—information CMS might not otherwise capture without flexibility in PRO-PM selection. If CMS instead plans to limit which PRO-PMs are eligible for this incentive, ACS recommends that CMS announce the candidate PRO-PMs as early as possible and give stakeholders an opportunity to comment on that selection before finalizing it.

ASM Participant Exceptions

Exceptions Due to Heart Failure-Related Specialty Type Redesignations

CMS proposes a process for ASM Heart Failure participants to redesignate their primary specialty type and be exempt from specific ASM requirements. **ACS supports this proposal and thanks CMS for recognizing that certain cardiac subspecialists, including cardiac surgery, have focused practice areas distinct from the broader cardiovascular disease and heart failure management captured under the cardiology specialty and reflected in the ASM cohort.**

The ACS also recommends CMS extend similar exemptions to certain specialties captured in the ASM low back pain cohort and consider how to incorporate an exemption or pathway for optional participation for those who achieve QP status through an Advanced APM and clinicians who fall below the MIPS low-volume threshold.

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In ACS' comments to the ASM proposals in the CY 2026 PFS proposed rule, we highlighted concerns with the cost and quality components, as they lack relevance and applicability to many members of the clinical team taking care of patients with low back pain, such as orthopedic surgeons or neurosurgeons. From the ACS perspective, a fundamental flaw in the model is using the MIPS episode-based cost measures to determine if an individual is eligible for an ASM cohort. 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. The judgment applied to determine what is in the control of a specific physician is statistically "noisy" at best because specialty 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. 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 similar to the cost methodology used in the EGM.

Quality Measure Lack Relevance to Surgical Specialties

In addition, 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. Instead of defining quality measures that are broadly applied at the individual level, **ACS supports model accountability for quality that focuses 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 major and minor complications, as well as have the ability to rescue patients**.

Finally, MIPS exceptions, such as the low volume threshold exception or the MIPS exemption for clinicians who achieve QP status through an Advanced APM, do not carry over to ASM. This is problematic for QPs because this will layer ASM requirements on top of existing Advanced APM participation, creating duplicative burden and potentially conflicting incentives. Additionally, the ASM will pull in clinicians who may not be required to participate in MIPS because they do not meet the MIPS low volume threshold. These clinicians may not have the infrastructure to meet the MIPS quality measure, Promoting Interoperability (PI), or Improvement Activity (IA) requirements in ASM. For these clinicians, mandatory participation in ASM would pose major burden, therefore, ACS recommends that CMS should either offer an exemption or create an optional participation pathway for those exempt from MIPS reporting.

UPDATES TO THE QUALITY PAYMENT PROGRAM (QPP)

Transforming MIPS: MIPS Value Pathway (MVP) Strategy

Beginning with the CY 2029 performance period, CMS proposes that all Merit-based Incentive Payment System (MIPS) eligible clinicians, with the exception of clinicians reporting through the APM Performance Pathway (APP), would report through an MVP. CMS anticipates that nearly all MIPS eligible clinicians will be able to choose an applicable MVP. ACS challenges this assumption. An MVP

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may technically apply to a clinician without meaningfully assessing the nuances of their work, reinforcing the perception among many physicians that MIPS and MVPs are low-value and burdensome.

While the goals of MVPs—to provide more clinically cohesive sets of measures and reduce reporting burden—are a partial improvement over traditional MIPS, the ACS does not agree that MVPs are an effective value-based strategy that will meaningfully move the quality needle for surgery, but instead a reshuffling of the same failed MIPS framework. The ACS maintains its longstanding concerns with MVPs and ultimately sees the program as a way to fulfill a payment mandate, not a quality-improvement mechanism.

As mentioned throughout our comments, a foundational concern is that MVPs measure the individual clinician rather than the care team, even though high-quality surgical care is the result of a high-functioning team caring for patient populations with varying risk. For value-based care to exist, the unit of analysis must shift from the individual surgeon to episodes of care aggregated at the level of the facility for both quality and cost measurement. As ACS describes in the responses to the Specialty Care in the Shared Savings Program RFI, episode-based measurement aggregated at the team or group level better reflects how care is delivered, creates shared accountability across the care team, and gives patients more meaningful, comparable information.

We highlight additional existing concerns with the MVP framework below:

- 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;
- Measures that often focus on rare events producing case numbers with insufficient precision or meaningful confidence intervals;
- Limited availability of PROs in surgical care to incentivize goal-concordant care;
- Limited utility for patient and caregiver informed decision making—this extends to patient advocates, such as primary care providers (PCPs) and other healthcare providers;
- Little information that drives meaningful improvement in surgical care with a very long lag time.

The measures included in the Surgical Care MVP illustrate the problem; instead of capturing patient-centered goals, several are isolated process measures, and the majority are rare adverse events which do not have case numbers for reliability when measured at the individual level. When CMS designs MVPs, it should evaluate MVP measure options for their value and importance to patients and referring physicians. For example, whether patients meet post-operative functional goals, whether a procedure met its intent and the patient's expectations, and whether the surgical team operates within effective systems and participates in quality programs. Adverse events measures are important, but individually and in isolation they are not complete measures of quality. **As CMS develops or updates MVP measures it should move toward risk-adjusted measures that capture the care team's avoidance of all major complications, aligned with team competencies and patients' expected goals, rather than a handful of isolated rare events rates. As noted above, MVPs largely reshuffle the existing MIPS measure inventory rather than replacing it; CMS should not mandate their use until it fixes that underlying problem—an insufficient inventory of meaningful measures that reflect how care teams actually work together. One example CMS could pursue is an Age Friendly MVP for**

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surgical care, aligned with the goals of the Age Friendly Hospital Measure in the Hospital Inpatient Quality Reporting (IQR) program. This would build an MVP around a programmatic-based approach that reflects team and system level quality, rather than isolated metrics, and complement the work surgeons are already doing within their institutions to meet Age Friendly standards.

Examples like this show that MVPs can work when built around programmatic, team-based measurement. Ultimately, **ACS recommends that CMS use MVPs as a step to team-based, episode-based, patient-centered value—not the endpoint. As the College has urged CMS in the past, a solution starts with refocusing the QPP on the patient**—beginning with the measure-inventory problem described throughout this section.

Fast Healthcare Interoperability Resources®-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs - RFI

CMS states it plans to transition existing quality measures and reporting processes to FHIR-based dQMs with a 2-year transition timeline for the QPP that would begin with the CY 2028 performance period/2030 MIPS payment year. CMS seeks input on a transition timeline, key milestones, and implementation considerations for FHIR-based quality reporting in the QPP and other CMS clinician and hospital quality programs.

ACS thanks CMS for its efforts to advance quality measurement and views the transition to FHIR-based dQMs as a positive step toward interoperability, automated data retrieval, reduced burden from manual abstraction, and a learning health system. However, we cannot stress enough the importance of using this transition as an opportunity to build a new measure framework that incentivizes team-based, patient-centered care—not simply to digitize the measures already in use. Done well, this transition creates a strong foundation for the future uptake of clinically meaningful, innovative, real-time quality mechanisms.

In ACS' past comments on this topic, we recommended CMS pursue a glidepath to digital quality measures that capture structured data within the EHR and other clinical data sources, such as clinical data registries, while also leveraging advanced technologies—including Artificial Intelligence (AI)-enabled tools deployed within HIPAA-compliant environments—to draw additional context from unstructured data**.** Patients' data live in more than one EHR system. Aggregating the data needed to optimize care still lacks complete FHIR-based readiness, and standardized data that should be structured requires transformation which is not without cost. Structured, standardized clinical data should be treated as ground truth, but much of what defines a patient's care journey, and the relationship between physician and patient, lives in the unstructured record. Combining both structured and unstructured data sources will enable more innovative, clinically meaningful quality measurement going forward. The sections below outline ACS's recommendations on measure readiness, infrastructure readiness, priority areas for investment, and how ACS can partner with CMS in this work.

Prioritize Quality Measure Meaningfulness, Not Just Measure Digitization

During the 2-year transition period, existing quality collection types for CQMs and eCQMs, including eCQM reporting via Quality Reporting Data Architecture (QRDA) files, would continue to be available

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while FHIR-based dQM options are introduced for selected measures. The transition will likely begin with a limited set of measures for which FHIR-based digital specifications are available and expand over time as technical infrastructure and implementation experience grow.

The ACS strongly supports digitizing measures that are clinically meaningful and patient-centered. The automation of meaningful measures and the ability to capture quality data closer to real-time has the potential to greatly reduce administrative burden and leverage data in innovative ways. Alongside efforts to convert existing measures to dQMs, ACS supports the gradual transition to new reporting mechanisms and recommends CMS evaluate the existing measure inventory to prioritize high-value measures as they take steps to build out digital measures.

However, this effort must not simply make it easier to report measures that already 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. Without critical evaluation, digitizing risks perpetuating the collection of low-value data rather than addressing the core issue: the need to retire or redesign measures that do not drive real improvements in care.

In addition, implementing technology solutions is not without capital expenditure. There are no plug-and-play applications, and customization and testing are required to ensure proper implementation. When that investment is directed toward measures with limited potential for real impact it diverts resources from meaningful improvement. Consider an academic medical center measuring a traditional, rare adverse event whose care team receives a rank-order report showing performance in the lower third of its comparator group. Despite no evidence of patient harm from the payer's analytics, the impact is still costly as resources are reallocated to begin a root cause analysis. The result is unwarranted expenditures diverted from other efforts, without a full understanding of whether the lower ranking reflects a true difference in quality.

This is a consequence of ranking providers on rare events. When an outcome is infrequent, each provider's performance rate rests on very few cases, so small differences in case counts produce large swings in apparent performance. Much of the separation between "top tier" and "lower-tier" providers therefore reflects case volume and chance rather than real differences in care, and a provider can move between tiers from one period to the next without any significant changes in care delivery. Digitizing a measure does not solve this underlying reliability issue, instead, it automates the reporting of a statistically fragile signal.

As CMS moves forward with the transition to digitally enabled quality measures, it is essential that they take advantage of this unique opportunity to redefine quality measurement and develop new innovative measures that reflect the diversity of medicine and ensure physicians can meaningfully show the quality of care they provide. Instead of just digitizing existing measures, CMS should:

- **Review existing measures for clinical relevance and patient centricity;**
- **Retire or revise those that do not meaningfully reflect quality or outcomes; and**

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- **Replace 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 constrained by the limitations of specific payment systems.**

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

Pace Implementation to Match Infrastructure Readiness

CMS asks numerous questions about factors that affect readiness for FHIR-based reporting. CMS discusses sunsetting these existing collection types once FHIR-based reporting becomes mandatory. While the existing pathways remain available, clinicians facing barriers to FHIR uptake can continue to participate in quality programs as they do today. However, once the transition period ends, those pathways are no longer available. **ACS agrees that a transition to dQMs is necessary, but it is important that required implementation of dQMs does not outpace the readiness of the digital infrastructure**—both within the site of care and across the external systems it depends on—for FHIR-based exchange**. ACS urges CMS to consider ways to tier implementation based on readiness for certain stakeholders and settings—including determining retirement of eCQMs and CQMs on demonstrated readiness rather than a fixed date.** A readiness-based sunset ensures no clinician loses the ability to participate simply because the infrastructure has not yet reached them. CMS and ONC have made great progress through regulatory efforts to make data more available and hold technology developers and EHR vendors accountable for compliance. However, substantial variance remains across the data and information systems used nationally. Several specific gaps illustrate why a readiness-based implementation should be considered:

- **Small and rural practices lag in adoption,** and because these practices can be exempt from the Promoting Interoperability performance category, that exemption may have further reduced their incentives to implement certified EHR systems.[39]

- **Ambulatory Surgery Centers (ASCs) and post-acute care (PAC) settings were not included in federal EHR incentive programs.** The HITECH Act incentivized EHR adoption for physician offices and hospitals, but not ASCs or long-term and PAC settings—so while hospital systems and many physician offices now have EHR infrastructure ready for dQMs, other settings, such as ASCs still rely on paper records or ASC-specific data systems, which can contribute to challenges with coordinating care across settings. Additionally, given the large and growing share of surgical procedures performed in ASCs, this may present a major problem in aggregating longitudinal patient data, especially for surgical procedures.

- **Even certified systems have immature FHIR capabilities.** Certification tests conformance, not real-world Application Programming Interface (API) performance, and Bulk FHIR—the

[39] Anzalone AJ, Geary CR, Dai R, Watanabe-Galloway S, McClay JC, Campbell JR. Lower electronic health record adoption and interoperability in rural versus urban physician participants: a cross-sectional analysis from the CMS quality payment program. *BMC Health Serv Res*. 2025;25(1):128.

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population-level mechanism dQMs need to aggregate quality data—remains early-stage and thinly deployed compared to single-patient FHIR.[40] Compounding this, legacy and outside-system data are not required to be mapped to United States Core Data for Interoperability (USCDI)/US Core terminologies, so a certified API can legitimately return incomplete or unmapped historical data—a particular problem for capturing longitudinal surgical outcome measures.

- **Health Information Exchanges (HIEs) infrastructure is not fully built.** HIEs and Qualified Health Information Networks (QHINs) create the opportunity for more complete protected health information (PHI) to be captured in patients' records regardless of where care was received—a capability that will be essential to aggregating accurate longitudinal data for dQMs. However, gaps remain: while QHINs are only required to enable FHIR API exchange (the functionality is available, but it is up to participants to use it), Bulk FHIR—the population-level mechanism dQMs depend on to aggregate quality data at scale—is not yet required under the QHIN Technical Framework. **ACS recommends CMS work with ONC to align the dQM transition with FHIR capabilities in QHINs so these networks can be effectively leveraged to capture accurate, longitudinal data.**

Areas Where Additional Investment is Required

ACS thanks CMS for seeking feedback to identify where readiness gaps exist. In this section we offer recommendations on where CMS should focus its efforts and resources to ensure successful implementation of FHIR-based dQMs, recognizing that meaningful progress toward more advanced quality measurement will require sustained investment in infrastructure.

1. **Provide targeted assistance and a glidepath for small and rural practices, ASCs, and other under-resourced settings.** CMS should provide targeted funding and technical assistance to the practices and settings least equipped to make this transition, including small and rural practices and ASCs. We recommend CMS consider how to create a tailored glidepath to dQM reporting that incentivizes uptake of dQMs while also allowing enough time for implementation, and that any technical assistance be tailored to setting—recognizing that a small rural practice and hospital-based system face very different readiness challenges.

2. **Invest in partnerships with specialty societies.** CMS should invest in partnerships with specialty societies to build out the library of available dQMs. Specialty societies are well-positioned to define data elements and value sets needed to capture surgical data accurately for quality measurement. Closing the gap between what CEHRT currently captures and exchanges, and what should be meaningfully captured for quality measurement will need deliberate, clinically informed investment.

[40] Jones JR, Gottlieb D, McMurry AJ, et al. Real-world performance of the 21st Century Cures Act population-level application programming interface. *J Am Med Inform Assoc*. 2024;31(5):1144-1153.

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3. **Support a glidepath for unstructured data.** Structured, standardized data elements in the EHR should be treated as ground truth, but so much of the context of surgical care is captured in the non-structured data in the record. CMS should support the development of measures that leverage AI-enabled tools to make that information usable for quality assessments.

4. **Pilot and stage the transition.** CMS should begin with a limited set of measures, as proposed, and build clinician-facing validation and feedback into each stage before transitioning to mandatory dQM reporting—using the transition as an opportunity to build toward a new measure framework that incentivizes team-based, patient-centered care, rather than simply digitizing the measures already in place. A phased rollout gives CMS the runway to test, validate, and refine these new measures alongside stakeholders before they carry full weight in payment or scoring. ACS welcomes the opportunity to partner with CMS in this work. ACS is undertaking a similar transition through its multi-year Clinical Data Strategy which will modernize NSQIP, NSQIP Pediatric, and Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) onto a shared community registries platform. This effort reflects ACS's commitment to modern, reliable, valid clinical data infrastructure that supports improved surgical care, and ACS welcomes the opportunity to align with CMS' quality programs.

Conclusion

ACS urges CMS to build adaptability into this transition. As outlined above, successful implementation depends on pairing measure digitization with critical evaluation of measure value, pacing implementation to match real-world infrastructure readiness, and directing investment to the practices and settings least equipped to keep pace. Beyond these specific recommendations, CMS should ensure the underlying framework itself remains flexible. Regulation and certification cycles are consistently outpaced by advances in data and AI capabilities, and a framework tied to today's FHIR, eCQM, and quality measurement landscape risks becoming outdated before the transition is even complete. CMS should build mechanisms to update standards, value sets, data elements, and measure logic outside the constraints of a full rulemaking cycle, paired with regular feedback loops, openness to innovative, AI-derived measures as these mechanisms mature and can be validated.

Finally, as CMS continues to implement dQMs, ACS encourages CMS to explore how AI-enabled tools can be leveraged not just to ease this transition, but to reshape quality measurement itself, capturing the full scope of patient care, including team-based and patient-centered outcomes that structured data alone cannot reflect. ACS appreciates CMS's leadership on this transition and looks forward to continued partnership toward a more interoperable, less burdensome, and more meaningful quality enterprise.

Quality Performance Category

Proposal to Designate MIPS Core Measures

Beginning with the CY 2027 performance period, CMS proposes to implement the MIPS Core Measure designation in traditional MIPS and MVPs, with the goal of providing patients with comparative

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clinician performance data to make better quality assessments. For each MVP, CMS proposes to select the MIPS Core measures from that MVP's already-assigned MIPS quality measures, with a minimum of three Core measures per MVP, designating more than three when necessary to reflect the subspecialties central to that MVP.

The ACS appreciates CMS' recognition that patients need more meaningful information, but ACS does not agree that CMS's proposed framework for MIPS Core Measures will achieve this goal. If CMS moves forward with Core Measures, ACS recommends using PRO-PMs for surgical care: since they apply across specialties and procedures, they can assess whether surgery achieved patient goals of care and other outcomes patients value. ACS also urges CMS to incentivize PRO-PM reporting in MIPS, similar to the proposal to incentivize voluntary reporting of PRO-PMs in the ASM.

The broad scope of certain MVPs, such as the Surgical Care MVP, remains a core problem with MVPs as well as the Core Measures proposal. CMS states that the Surgical Care MVP is applicable to General Surgery, Neurosurgery, Cardiothoracic Surgery, Anesthesiologists, Nonphysician Practitioners, Certified Registered Nurse Anesthetists, Nurse Practitioner, and Physician Assistants,[41] yet each clinician group performs different procedures, treats different conditions, and carries different risks. The diversity within broad MVPs makes the measure data misleading for comparison, because it assumes that all surgeons or Advanced Practice Provider (APPs) are doing comparable work.

CMS' own designated Core measures for the Surgical Care MVP illustrate the problem, with exception of the *Patient-Centered Surgical Risk Assessment and Communication (Q358)*[42] measure which is patient-centered and the type of measure CMS should leverage as a Core Measure because it would help establish shared decision-making conversations, identify goals, and move towards patient-reported outcome measures (PROMs) that assess goal achievement. In contrast, *Advance Care Plan (Q047)*[43] applies to nearly all clinicians, but it is a documentation process measure that gives little indication about the quality of a surgeon's care. A patient choosing a surgeon learns little about the skill or outcomes from whether an advance care plan was documented, and for clinicians, improving a documentation rate does not distinguish or improve care. *The Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Q164)*,[44] in contrast, is meaningful only within a single procedure performed by a single specialty. This measure is not reportable by the general surgeons, neurosurgeons, or other clinicians CMS includes in this MVP. The measures broad enough to apply across the MVP are not

[41] Centers for Medicare & Medicaid Services. Surgical Care MVP (M1425). Quality Payment Program. Accessed September 9, 2026. https://qpp.cms.gov/reporting-requirements/measures-activities/explore-mvps/2025/M1425
[42] Centers for Medicare & Medicaid Services. Quality ID #358: Patient-Centered Surgical Risk Assessment and Communication. Quality Payment Program; 2021. Accessed September 9, 2026. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2021_measure_358_MIPSCQM.pdf
[43] Centers for Medicare & Medicaid Services. Quality ID #047: Advance Care Plan. Quality Payment Program; 2024. Accessed September 9, 2026. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2024_Measure_047_MIPSCQM.pdf
[44] Centers for Medicare & Medicaid Services. Quality ID #164: Coronary Artery Bypass Graft (CABG): Prolonged Intubation. Quality Payment Program; 2017. Accessed September 9, 2026. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2017_Measure_164_Registry.pdf

measures of surgical quality, while the measures that reflect surgical quality are each meaningful to only a narrow group of the MVP's clinicians and patients.

CMS's proposal to designate three or more core measures while requiring clinicians to report only one compounds the problem: two clinicians of the same specialty in the same MVP can satisfy the requirement by reporting entirely different Core Measures. The requirement therefore manufactures the appearance of comparability without the substance—the clinicians may have reported on different measures, different procedures, or even different specialties entirely. In ACS's view, real comparability requires procedure-specific, risk-adjusted measures.

Although we do not support the Core Measure concept because of the concerns outlined above, if CMS moves forward with this proposal, we urge CMS to focus on PROMs. We encourage CMS to incentivize the PRO-PM reporting to increase implementation and to capture more data to inform how PRO-PMs can be best utilized in CMS quality programs. Where clinical and adverse-event measures are procedure-specific and often too rare to be reliable at the individual level, PROs, by contrast, can be crafted to apply to every patient and capture outcomes patients care about—function, recovery, quality of life, and goal attainment. PRO-PMs are both clinically relevant and meaningful to patients, and therefore a better fit for designated Core Measures.

MIPS Promoting Interoperability

Proposal to Remove the Security Risk Analysis Measure

The Security Risk Analysis measure is based on the Health Insurance Portability Accountability Act of 1996 (HIPAA) Security Rule risk analysis requirement, which requires covered entities and business associates to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic PHI held by the covered entity or business associate. CMS proposes to remove the Security Risk Analysis measure beginning with the CY 2027 performance period to reduce reporting burden. Given that MIPS eligible clinicians are covered entities under the HIPAA Security Rule and the underlying security risk analysis and risk management activities are already required under the HIPAA Security Rule, CMS believes it may be unnecessarily costly and of limited incremental benefit to retain this measure. **The ACS supports the removal of the Security Risk Analysis measure as duplicative of the existing HIPAA requirements.**

At the same time, we urge CMS and the United Stated Department of Health and Human Services (HHS) to ensure that the underlying HIPAA Security Rule requirements keep pace with the rapidly changing technology environment. As EHR vendors increasingly integrate generative AI and agentic tools that process electronic PHI, the pathways for potential exposure and misuse of PHI are expanding in ways that existing risk analysis frameworks are not designed to address. Removing the MIPS measure should not signal that security oversight is less important; instead, it is an opportunity to modernize the underlying requirements for the emerging AI era.

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Advanced APMs

Applying QP Determinations at the TIN/NPI Level

CMS proposes to apply QP and Partial QP status at the TIN/ NPI level, instead of the NPI-level, and for APM incentive payments and QP conversion factor adjustments. Going forward, the APM Incentive Payment and QP conversion factor adjustment would apply only to the clinician's APM-relevant TINs. This would also apply to the ability of a Partial QP to opt into or out of MIPS. **The ACS supports this change because it takes steps to create more fairness in the distribution of APM incentive payments and conversion factor adjustments, preventing them from flowing to TINs that are not participating in Advanced APMs.**

In addition, 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 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. Clear incentives are 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. While this proposal is a welcome update, with the Advanced APM incentive payments no longer available and eligibility thresholds increasing, many specialists may still not see the benefit of participating in Advanced APMs at this time.

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,

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