American Society for Gastrointestinal Endoscopy

New Medicare Practice Expense Policy Harms Physician Practices

Issue Background

The Centers for Medicare and Medicaid Services (CMS) finalized a rule on October 31, 2025, changing the methodology for determining indirect practice expense (PE) payments for services delivered by physicians in facilities. Effective January 1, 2026, indirect PE relative value units (RVUs) are reduced by 50 percent for physician services furnished in hospitals, hospital outpatient departments and ambulatory surgery centers (ASCs). CMS seeks, with its new policy, to update payment policies as physician employment has risen amid market consolidation. The new PE methodology challenges the assumption that facility-based physicians are responsible for the expenses of maintaining an office. The rule, however, overreaches by imposing a one-size-fits-all adjustment without differentiation for independent physicians versus those employed by facilities.

The Impact on Physician Practice

The intended effect of CMS' change in the indirect PE methodology is to redistribute Medicare dollars from facilities to private practice. Unfortunately, the sweeping methodological overhaul disproportionately penalizes private practice physicians who deliver services in ASCs and hospitals. **For core gastrointestinal endoscopy services performed in facility settings, the policy reduces PE RVUs by approximately 25% and total physician payment by roughly 7%**, despite the fact that gastroenterologists—regardless of employment status or site of service—continue to incur substantial PE obligations, including staffing, clinical documentation, regulatory compliance, scheduling, and billing infrastructure.

CMS has cited overall payment increases for office-based gastroenterology as evidence the policy supports independent practice. However, this framing is disconnected from endoscopy practice patterns. Data show that for the highest volume colonoscopy (CPT® 45385 – colonoscopy with snare polypectomy), approximately 94% of Medicare fee-for-service volume is furnished in ASCs or HOPDs, with only 3% performed in the office. This distribution is structural, not discretionary, driven by longstanding regulatory, safety, and infrastructure requirements.

Endoscopy volume is not positioned to quickly migrate meaningfully to the office setting, and office-based payment gains, therefore, do not offset cuts affecting facility-dominant GI services. Contrary to CMS' stated intent, the policy will be particularly damaging to independent gastroenterology practices that own and operate ASCs.

Finally, the magnitude and immediacy of the redistribution threaten the viability of independent physician-owned ASCs — an outcome that runs counter to CMS' stated goals of promoting competition, access, and cost containment.

How Congress Can Help

Ask CMS to revisit its indirect PE policy for CY 2027 rulemaking and to consider a more discerning methodology—such as the use of a payment modifier or other mechanism—to distinguish between different practice arrangements.