December 22, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS-1832-F)

Dear Administrator Oz,

On behalf of the American College of Gastroenterology (ACG), American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE), to express our deep concern regarding the practice expense (PE) methodology changes finalized in the 2026 Medicare Physician Fee Schedule (CMS-1832-F). Together, our societies represent virtually all practicing gastroenterologists in the United States.

While we appreciate CMS's efforts to modernize the Resource-Based Relative Value Scale (RBRVS), the finalized practice expense (PE) revisions represent a fundamental shift in relativity that disproportionately and severely reduce PE RVUs for gastroenterology endoscopic procedures furnished in ambulatory surgery centers (ASCs) and hospital outpatient departments (HOPDs). For core GI 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 practice-expense obligations, including staffing, clinical documentation, regulatory compliance, scheduling, and billing infrastructure.

CMS has cited overall payment increases for office-based gastroenterology as evidence that the policy supports independent practice. However, this framing is disconnected from endoscopy practice patterns. AMA RUC 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's stated intent, the policy will be particularly damaging to independent gastroenterology practices that own and operate ASCs. These practices continue to bear significant indirect practice expenses even when procedures are performed in facility settings, including care coordination, coding and billing operations, quality reporting, and administrative staffing. CMS's assertion that physician-owned ASCs result in "duplicative payments" oversimplifies practice economics and ignores well-documented evidence that these costs persist regardless of site of service.

CMS applied the revised PE policy broadly across all HOPD and ASC services without differentiating between hospital-employed physicians and independent practices, despite MedPAC's recognition in its 2025 Report to Congress that such differentiation would be necessary to understand redistributive effects. Proceeding without this analysis risks mis-targeting payment reductions and undermining the very independent practices CMS seeks to support.

Finally, the magnitude and immediacy of the redistribution pose a serious risk of destabilizing GI care delivery. A 25% reduction in PE RVUs and a 7% cut in total payment, implemented without a phase-in, will accelerate consolidation, threaten the viability of independent physician-owned ASCs, and reduce patient access—particularly in community-based and rural settings. These outcomes run counter to CMS's goals of promoting competition, access, and cost containment, and may ultimately increase total Medicare spending by shifting care back to higher-cost hospital outpatient departments.

We therefore urge CMS to modify the policy beginning in CY 2027 to allow for appropriate differentiation among physician practice arrangements based on the following points.

- The policy further presupposes a rapid transition to office-based endoscopy that is neither feasible nor clinically appropriate.

- State licensure and certificate-of-need requirements, Medicare coverage limitations, anesthesia and recovery needs, and patient safety considerations preclude such a shift for most Medicare beneficiaries.
- Office-based endoscopy models exist only in limited circumstances and are not scalable across the specialty.
- A 25% reduction in PE RVUs and a 7% cut in total payment will accelerate consolidation and threaten the viability of independent physician-owned ASCs, outcomes that run counter to CMS's goals of promoting competition, access, and cost containment.

For these reasons, we respectfully request that CMS delay implementation of the revised PE methodology for gastroenterology endoscopy services until the Agency completes targeted, specialty-specific analysis and validates the policy's impact. A delayed and data-driven approach would align with CMS precedent, protect beneficiary access, and allow for thoughtful refinement of PE policy without destabilizing essential GI services.

Sincerely

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