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September 9, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1832-P 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

Dear Administrator Oz:

On behalf of the American Urogynecologic Society (AUGS), I am pleased to submit comments in response to the proposed rule for the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (CMS-1832-P). AUGS is a national medical society whose mission is to promote the highest quality of care in urogynecology and pelvic reconstructive surgery through excellence in education, research, and advocacy. Our comments address the following CMS proposals:

1. CY 2026 Conversion Factor Update
2. Methodology for Establishing Work RVUs – Proposed Efficiency Adjustment
3. Updates to Practice Expense Methodology – Site of Service Payment Differential
4. Supply Pack Pricing Update
5. Provider Home Address
6. Direct Supervision via Use of Two-way Audio/Visual Video Communications Technology
7. Proposed Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence

1. CY 2026 Conversion Factor Update

Proposed Rule: CMS proposes a CY 2026 Medicare Physician Fee Schedule (PFS) conversion factor (CF) of \$33.5875 for physicians who meet the participation threshold in Advanced Alternative Payment Models (APMs) and \$33.4209 for all other clinicians—an increase of 3.8% and 3.3%, respectively, from the CY 2025 final CF of \$32.3465. This update reflects: (1) the statutory update factor under MACRA (0.25% or 0.75%, depending on participation status); (2) a +0.55% budget neutrality adjustment funded by the proposed negative 2.5% efficiency adjustment to work RVUs; and (3) a one-year +2.5% increase authorized by Congress in the One Big Beautiful Bill Act (OBBBA), which will expire at the end of CY 2026.

AUGS Recommendation: While we appreciate that the CY 2026 proposed rule includes a modest positive CF update, the increase is partially offset by corresponding reductions to work RVUs—meaning physicians are, in effect, financing part of the update through cuts elsewhere. The largest single-year adjustment comes from a temporary +2.5% increase authorized by Congress, which is only in effect for 2026. Absent further legislative

action, this increase will expire at year's end, producing a significant reduction in 2027 on top of any other negative adjustments from statutory or budget neutrality factors. This is similar to what occurred in 2025, when the expiration of four consecutive years of short-term congressional relief triggered an immediate payment cut, demonstrating that reliance on temporary patches creates ongoing instability for physician practices. These circumstances highlight the broader structural flaws in the PFS rate-setting methodology, including outdated budget neutrality requirements and the absence of an annual inflationary update comparable to that provided to hospitals and other facility-based providers. The cumulative impact of ongoing cuts is especially concerning for access to care. Practices already report challenges sustaining Medicare participation, and persistent erosion of reimbursement risks reaching the point where some providers may exit Medicare altogether—reducing access, particularly in rural and underserved areas.

This year's proposed CF update also underscores inequities in the Quality Payment Program (QPP). Because the statutory CF update factor provides higher increases for clinicians who qualify as Advanced APM participants, specialties with more limited measure sets, such as urogynecology, are effectively excluded from accessing that higher update amount. This lack of robust and relevant measures creates a structural inequity that compounds the erosion of the CF. Independent practices, which are often lower-cost settings for Medicare, are disproportionately threatened by continued CF erosion—jeopardizing both access and cost containment goals.

While we recognize that CMS is constrained by statutory limits, the agency nonetheless plays a critical role in providing technical support to Congress on needed reforms. **AUGS therefore strongly urge CMS to work proactively with Congress to implement permanent, meaningful positive updates to the CF, modernize budget neutrality policy, and establish a stable, predictable payment system that reflects the real cost of delivering care in today's environment.**

1. Methodology for Establishing Work RVUs – Proposed Efficiency Adjustment

Proposed Rule: CMS proposes to apply an efficiency adjustment of 2.5% to work relative value units (RVUs) and intra-service physician time for certain non-time-based codes. The proposed efficiency adjustment is calculated by summing the last 5 years of the Medicare Economic Index (MEI) productivity adjustments. CMS proposes to update and apply this efficiency adjustment every three years.

AUGS Recommendation: **AUGS strongly opposes CMS's proposal to apply a 2.5% efficiency adjustment to work RVUs and intra-service physician time.** While AUGS supports empirically validating RVU accuracy, this proposal is based on flawed assumptions and would create significant unintended consequences for physicians and patients.

Flawed assumptions about efficiency and physician work. The proposal equates reductions in intra-service time with reductions in physician work, presuming that technological advances automatically translate to greater efficiency and less physician effort. While technologies can change how procedures are delivered, they often introduce new complexities that may increase, not decrease, the intensity of work. This can include steep learning curves, the need for greater precision, integration of new data into decision-making, and coordination with additional team members. Faster simply does not equate to less work.

Recent empirical evidence underscores this point. A 2024 study published in the *Journal of the American College of Surgeons* examined intra-service operative time across 1.7 million procedures covering 249 CPT codes across 11 specialties. The study found that operative times increased by 3.1% between 2019 and 2023, with 90% of procedures showing longer or unchanged times.ⁱ These findings directly contradict CMS's presumption that efficiency gains are reflected in shorter operative times, and demonstrate that surgical practice frequently becomes more complex as techniques evolve.

Even when procedures take less time, this does not necessarily mean reduced work. Shorter operative times often benefit patients by reducing anesthesia exposure, lowering complications, and shortening recovery. In women's health, minimally invasive urogynecologic procedures have reduced hospital stays while increasing the precision and cognitive burden for surgeons. **Policies that equate shorter time with less work risk discouraging innovation that improves patient outcomes and send the wrong signal about CMS's priorities for patient-centered care.**

Unintended impacts of physician compensation and practice stability. Many physicians, particularly in multi-specialty groups and health systems, are paid under productivity-based compensation models that tie earnings to work RVUs. According to the AMA Physician Practice Benchmark survey, more than half of physicians nationally receive compensation based on productivity, and a majority of ob/gyns rely on work RVUs in their compensation plans.ⁱⁱ A uniform reduction to work RVUs will directly reduce physician compensation, undermining recruitment and retention efforts, particularly in rural and underserved areas where workforce shortages already limit access.

Overbroad application. CMS proposes to apply the adjustment to all non-time-based services, regardless of whether those services have recently undergone rigorous review through existing processes. This includes codes that have been valued or revalued in recent years. The RUC process already provides a robust mechanism for identifying and correcting potentially misvalued services, ensuring that relative values remain accurate. Applying an across-the-board cut disregards this rigor and undermines the relativity of the physician work RVU system.

Inconsistencies with productivity adjustments in other payment systems. Productivity adjustments in the Hospital Inpatient and Outpatient Prospective Payment Systems (OPPS) are applied to the conversion factor, which itself is updated annually through a market basket inflationary adjustment (3.2% in the CY 2026 OPPS proposed rule, offset by a 0.8 percentage point productivity factor). By contrast, under the PFS, CMS proposes to apply the adjustment directly to the valuation of individual services—creating a permanent reduction every three years without an offsetting inflationary update. Given that PFS conversion factor increases are limited to only 0.25% or 0.75%, applying a recurring downward adjustment to work RVUs will significantly accelerate the erosion of physician payment levels over time. **Even if CMS believes aggregate MEI productivity adjustments are appropriate in other contexts, applying them indiscriminately at the service-level risks double-counting efficiencies already addressed through the RUC process.**

Impact on women's health care. For urogynecologists and other women's health specialists, the proposal fails to recognize the unique value of surgical and procedural care in managing chronic conditions such as pelvic floor disorders, which require ongoing, longitudinal management. These conditions do not become easier to treat simply because technology evolves. On the contrary, newer techniques can increase intensity and cognitive burden even if intra-service time declines. Undervaluing these services risks destabilizing practices and reducing access, particularly in rural and underserved communities.

For these reasons, AUGS strongly urges CMS not to finalize the proposed 2.5% efficiency adjustment in the CY 2026 PFS. We are not opposed to empirically validating RVUs, including more refined ways to capture efficiencies over time. However, the policy, as proposed, is overbroad, unsupported by evidence, and risks significant negative consequences. We urge CMS to withhold finalization until a more evidence-based, targeted methodology can be developed, and we stand ready to work with the agency toward that end. If CMS nevertheless finalizes the proposal for CY 2026, we request at minimum a one-year delay to CY 2027 to allow time for stakeholder analysis and input.

2. Updates to Practice Expense Methodology – Site of Service Payment Differential

Proposed Rule: CMS proposes revising the methodology for allocating indirect PE costs for facility-based services.

AUGS Recommendation: **AUGS strongly opposes the proposal to reduce the allocation for facility-based services by 50% of the non-facility amount.** While we appreciate CMS's effort to modernize the PE methodology and recognize the agency's stated concern regarding potential over-allocation of indirect PE in the facility setting, we urge the agency to work collaboratively with physician specialty societies to further study indirect PE costs across practice models and identify targeted, evidence-based approaches to address duplicative payments, if they exist.

Urogynecology relies on a combination of office-based and facility-based care to deliver comprehensive treatment. While many complex procedures, such as advanced pelvic reconstructive surgeries, are necessarily furnished in hospital or ambulatory surgical center settings, these services are supported by the same practice infrastructure used for non-facility care. This includes pre- and post-operative visits, administrative and billing staff, coding and compliance functions, electronic medical record systems, and patient education. Practices also incur costs for clinical coordination, including central staff who manage operating room scheduling, pre-operative testing, and post-operative follow-up, as well as long-term management of chronic pelvic floor conditions in the office setting. These costs persist regardless of where the procedure is performed and are not reimbursed through the facility payment.

We also note that CMS's concern appears to focus on hospital-employed physician arrangements, where duplicative indirect costs may arise. However, a uniform 50% reduction does not distinguish between these arrangements and independent practices that continue to incur substantial indirect costs. **This blunt approach risks destabilizing independent practices that play a key role in maintaining access.** If CMS nevertheless decides to move forward with this proposal, we strongly urge the agency to: (1) apply a reduction of less than 50%, and/or (2) consider a phase-in approach, as CMS has done other instances, and/or (3) explore targeted adjustments focused on hospital-employed physician arrangements without penalizing independent practices.

3. Supply Pack Pricing Update

Proposed Rule: CMS proposes repricing several supply packs, including an 86 percent reduction to the pelvic exam pack (SA051), phased in over three years.

AUGS Recommendation: **AUGS appreciates CMS's recognition that a sudden 86 percent reduction to the pelvic exam supply pack would be highly disruptive and the proposal to phase in the correction.** Pelvic examinations are a critical component of women's health. A sudden, dramatic decrease in the price of the supply pack risks undermining access to these essential services. While we recognize CMS's intent to correct mispricing, we remain concerned that even a phased-in reduction will materially decrease practice expense RVUs for a broad range of services, including those commonly furnished by urogynecologists. Given that supply and labor costs continue to rise due to inflation and market pressures, the proposed reduction simply does not reflect the realities of practice expenses in today's environment.

AUGS is considering submission of updated invoices and cost data related to the pelvic exam supply pack and would welcome the opportunity to engage with CMS further to ensure pricing accurately reflects costs across a range of practice settings. **We urge CMS to incorporate stakeholder input and updated data as part of**

future PFS rulemaking, to ensure that supply pack pricing appropriately captures the costs practices incur and does not inadvertently reduce reimbursement for essential women’s health services.

4. Provider Home Address

Proposed Rule: During the COVID-19 Public Health Emergency (PHE) and continuing through CY 2025, CMS permitted distant site practitioners to use their currently enrolled practice location, rather than their home address, when furnishing telehealth services from their home. This flexibility is set to expire on December 31, 2025, and the proposed rule does not include discussion of or an extension to this policy.

AUGS Recommendation: We urge CMS to finalize the continuation of this policy for CY 2026 and beyond. **Public display of clinicians’ home addresses raises significant privacy concerns, and eliminating this flexibility would increase administrative burden by requiring updates to enrollment records.** Practice addresses already ensure transparency without compromising safety. To protect clinician privacy and minimize unnecessary administrative work, **AUGS strongly recommends that CMS make this policy permanent.**

5. Direct Supervision via Use of Two-way Audio/Visual Video Communications Technology

Proposed Rule: CMS proposes to permanently adopt a definition of direct supervision that allows “immediate availability” of the supervising provider via real-time, two-way audio-video communications technology (excluding audio-only) for all services except those with 10- and 90-day global surgery periods.

AUGS Recommendation: **We support CMS’s proposal to permanently adopt a definition of direct supervision that allows “immediate availability” through real-time, two-way audio-video communications technology for all applicable services.** This policy has proven valuable in facilitating timely supervision, improving practice efficiency, and supporting patient access. We encourage CMS to continue evaluating whether these flexibilities could be extended to additional service categories over time.

6. Proposed Changes to Teaching Physicians’ Billing for Services Involving Residents with Virtual Presence

Proposed Rule: CMS proposes to end—after December 31, 2025—the temporary policy that allows teaching physicians to be virtually present during the key portion of a Medicare telehealth service via real-time audio-video technology in all residency training locations. CMS would revert to the pre-PHE policy, maintaining only the rural exception established in the CY 2021 PFS final rule to support medical education opportunities in rural settings.

AUGS Recommendation: **We do not support CMS’s proposal to end the temporary policy allowing teaching physicians to maintain a virtual presence during the key portion of Medicare telehealth services in all residency training locations.** Limiting this flexibility to rural sites risks undermining training opportunities at a time when workforce shortages in women’s health are acute.

Adequate training of the reproductive health care workforce, including urogynecology, is essential to ensuring access to comprehensive care, from contraception to obstetric and surgical services. In urogynecology, this flexibility has facilitated supervision of subspecialty consultations, post-operative follow-up visits, and complex pelvic floor disorder management across health systems with multiple practice locations. Maintaining this flexibility permanently would help ensure that trainees in all geographic areas are able to access the full spectrum of women’s health education. **We therefore recommend that CMS make permanent the policy allowing teaching physicians to be virtually present in all teaching settings, not just rural ones, when the service is furnished virtually.**

Thank you for the opportunity to provide comment for your consideration. If AUGS can provide CMS with additional information regarding these matters, please contact me at 301-273-0570, ext. 116 or email Stacey@aug.s.org.

Sincerely,



Stacey Barnes
AUGS CEO

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ⁱⁱ Rama, A. Physician Compensation 2012-2022: Physicians Increasingly compensated through Multiple Methods. American Medical Association. Policy Research Perspective. 2024. Available at: <https://www.ama-assn.org/system/files/2022-prp-physician-comp-methods.pdf>.