MPFS Structural Reform: Stabilizing Independent Physicians and Rationalizing Ambulatory Care

Sreejit Nair, MD

Sunrise Vascular

New Cardiovascular Horizons

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Disclosures

- Distal
- Vasorum
- Provisio Medical
- Argon Medical Devices

Office-Based Setting compared with ASC and Hospital Settings

Hospital

Most expensive setting

Emergent capabilities

All services

Mostly urban

ASC

Cost less than hospital

General anesthesia

Surgical Services

Mostly urban

CON restrictions

Office

Lowest cost

Conscious sedation

Minimally-invasive procedures*

Urban and rural

* Such care crosses a wide range of specialties, including cardiology, interventional radiology, pain medicine, proton therapy, radiation oncology, urology, vascular surgery, and more.

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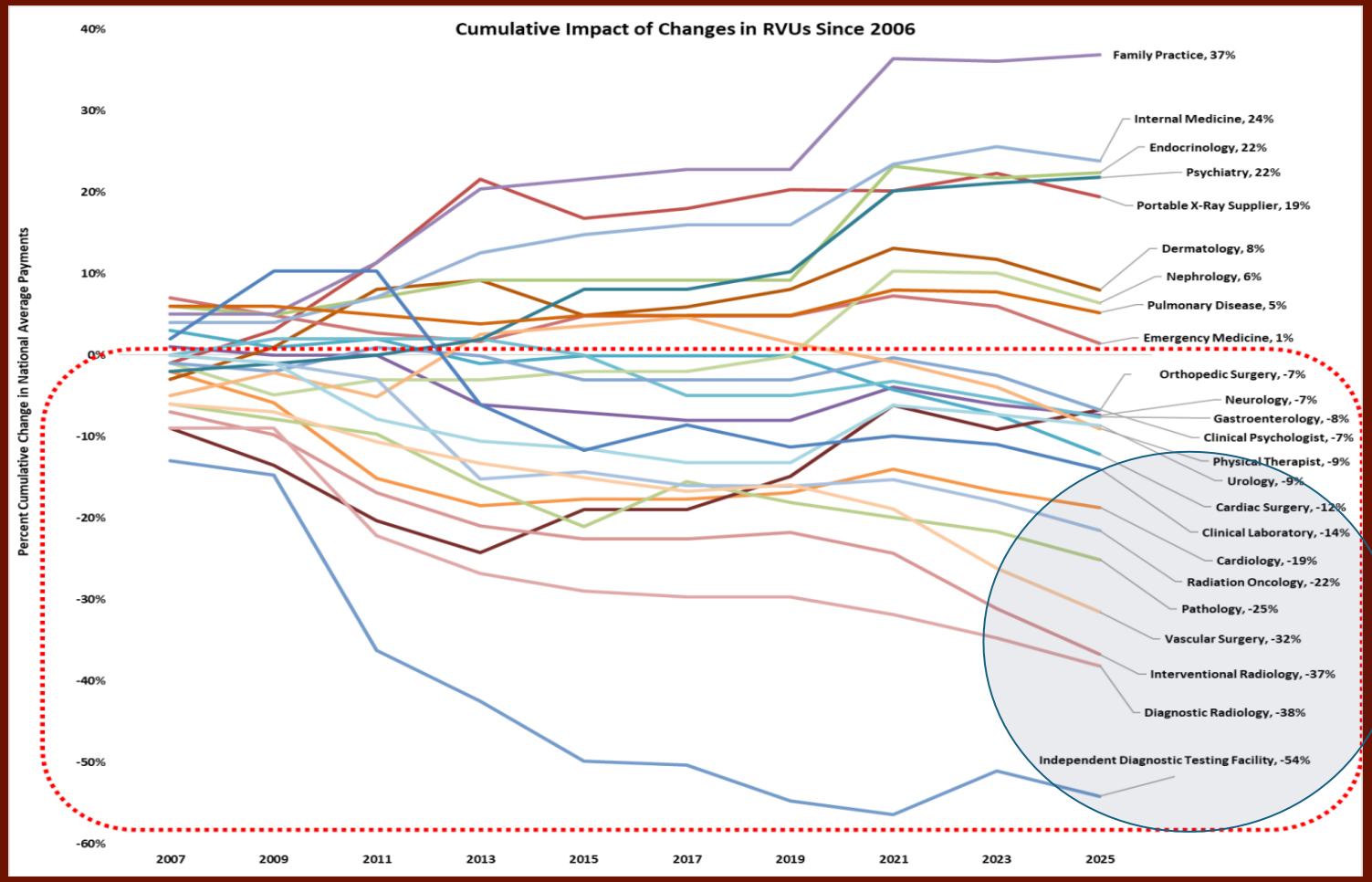
Ongoing Physician Fee Schedule Cuts Have Crushed Office-Based Procedural Care



Source: HMA analysis 2007-2025 Medicare Physician Fee Schedule Impact Tables. The values presented for 2021-2025 are adjusted to reflect the effects of the CAA, 2021, 2022, 2023, 2024 and the expected conversion factor reduction in 2025.

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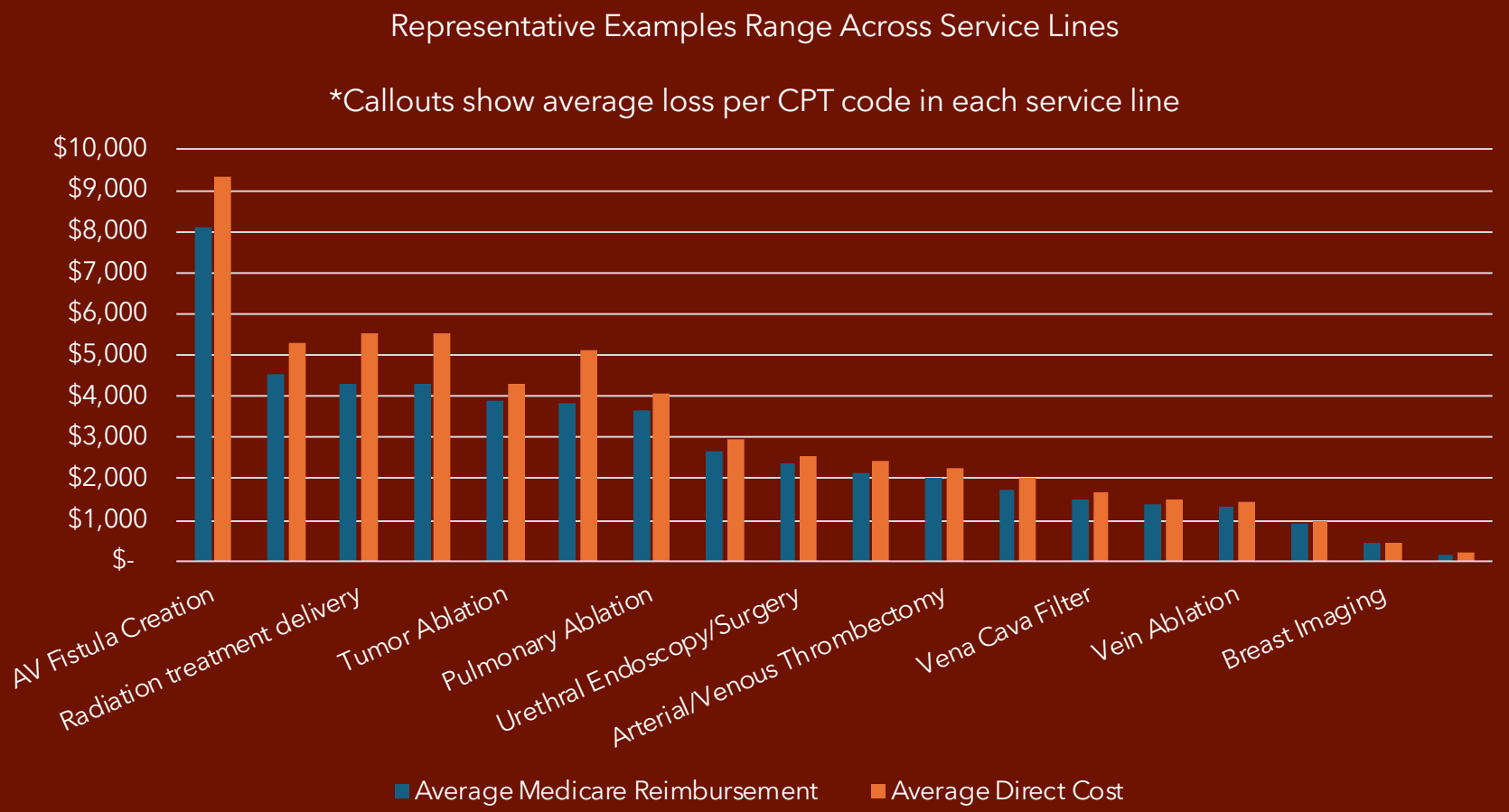
Medicare Physician Fee Schedule Reimbursement in 2025 Was Less Than Costs for At Least 300 Office-Based Procedural and Related Services in the PFS

In 2025, according to CMS data, there were 300 CPT codes – all office-based codes in the community setting – for which total reimbursement was less than their direct costs. In other words, payment was insufficient for these codes before even considering the added costs associated with indirect costs, provider work, and malpractice insurance.



1. Data is based on 2025 Physician Fee Schedule Final Rule Total Non-Facility Reimbursement and Total Direct Costs.
2. Radiation Treatment Delivery data assumes 25 fractions for typical prostate cancer patient. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9441303/ .

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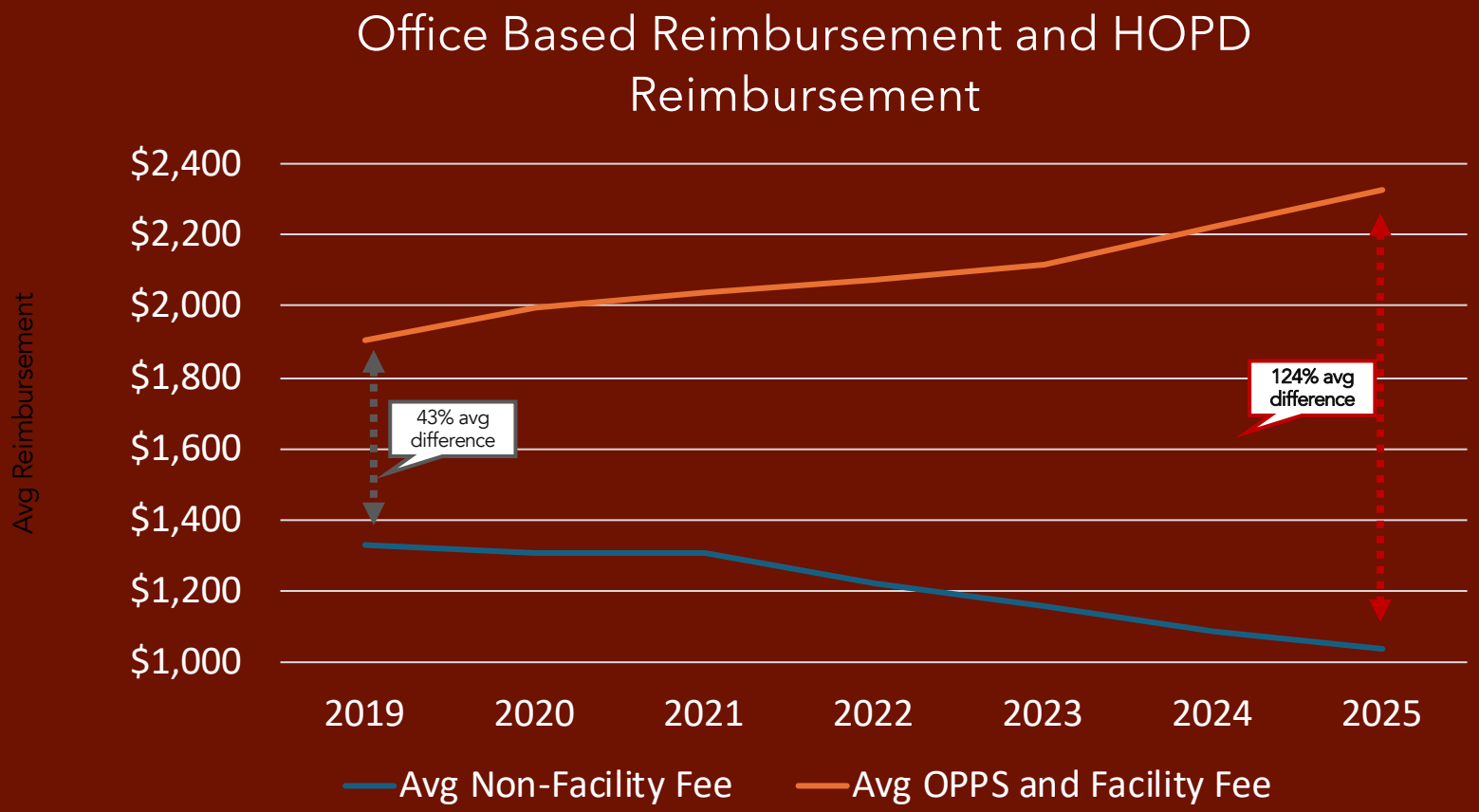
Average Office and HOPD Reimbursement of 300 Underpaid Codes

As reimbursements for high-tech procedures decrease in the office setting, the same services provided in the hospital show significant increases, further driving hospital consolidation and closing office-based centers.



1. Reimbursement is calculated as the average PFS non facility fee compared to the average PFS facility fee plus the average HOPD OPPS fee
2. Graph shows 273 of the 300 codes where total reimbursement is less than direct costs. 27 CPT codes were excluded as they were added to the fee schedule after 2019.

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Medicare Physician Fee Schedule – how is it calculated?

- **The Master Formula**
  - Payment = (work RVUs x work GPCI) + (PE RVUs x PE GPCI) + (MP RVUs x MP GPCI)
- **The Three RVU Components**

1. **Work RVU (wRVU):** Measures the time, technical skill, and intensity required of the provider.
2. **Practice Expense RVU (PE RVU):** Accounts for overhead, including clinical staff wages, medical equipment, and office supplies.
3. **Malpractice RVU (MP RVU):** Represents the relative cost of professional liability insurance.

Practice Expense – 2026 changes

Practice Expense RVU (PE RVU)

a) Direct Expense – Cost of supplies for a given service/procedure

b) Indirect Expense – Rent, staff wages, etc

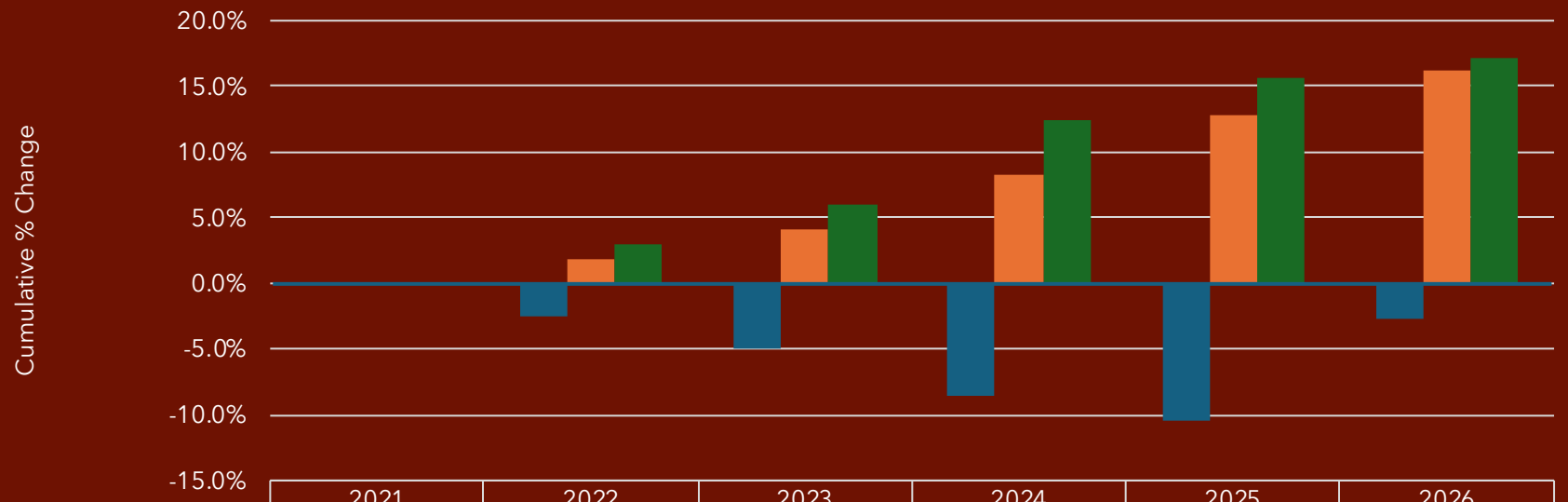
c) In 2026, CMS increased indirect practice expense valuation in the office setting, which resulted in increased reimbursement for office-based procedures. The Direct Expense valuation remained the same.

The Impacts of the 2026 PFS Final Indirect Practice Expense (IPE) Policy

The 2026 PFS Final Rule is the first meaningful improvement for office-based providers in years. The 2026 PFS Final Rule brings an increase for all three settings, despite non-facility settings remaining at a net negative.

HOPD and ASC rates continue to rise, largely unaffected by the IPE policy. An analysis of all codes common to HOPD, ASC, and non-facility settings over a 5-year period shows global facility rates have never declined year-over-year, while non-facility settings declined each year through 2025.

Cumulative Reimbursement Shifts Relative to 2021 Rates
Percent Variance 2021 - 2026 for All Reimbursable Codes in HOPD, ASC, and Office Settings
*only includes codes with pay data from 2021 - 2026 in all three fee schedules



	2021	2022	2023	2024	2025	2026
PFS Non-Fac	0.0%	-2.5%	-4.9%	-8.6%	-10.5%	-2.8%
HOPD and PFS Fac	0.0%	1.8%	4.1%	8.4%	12.8%	16.2%
ASC and PFS Fac	0.0%	3.0%	6.0%	12.4%	15.7%	17.2%

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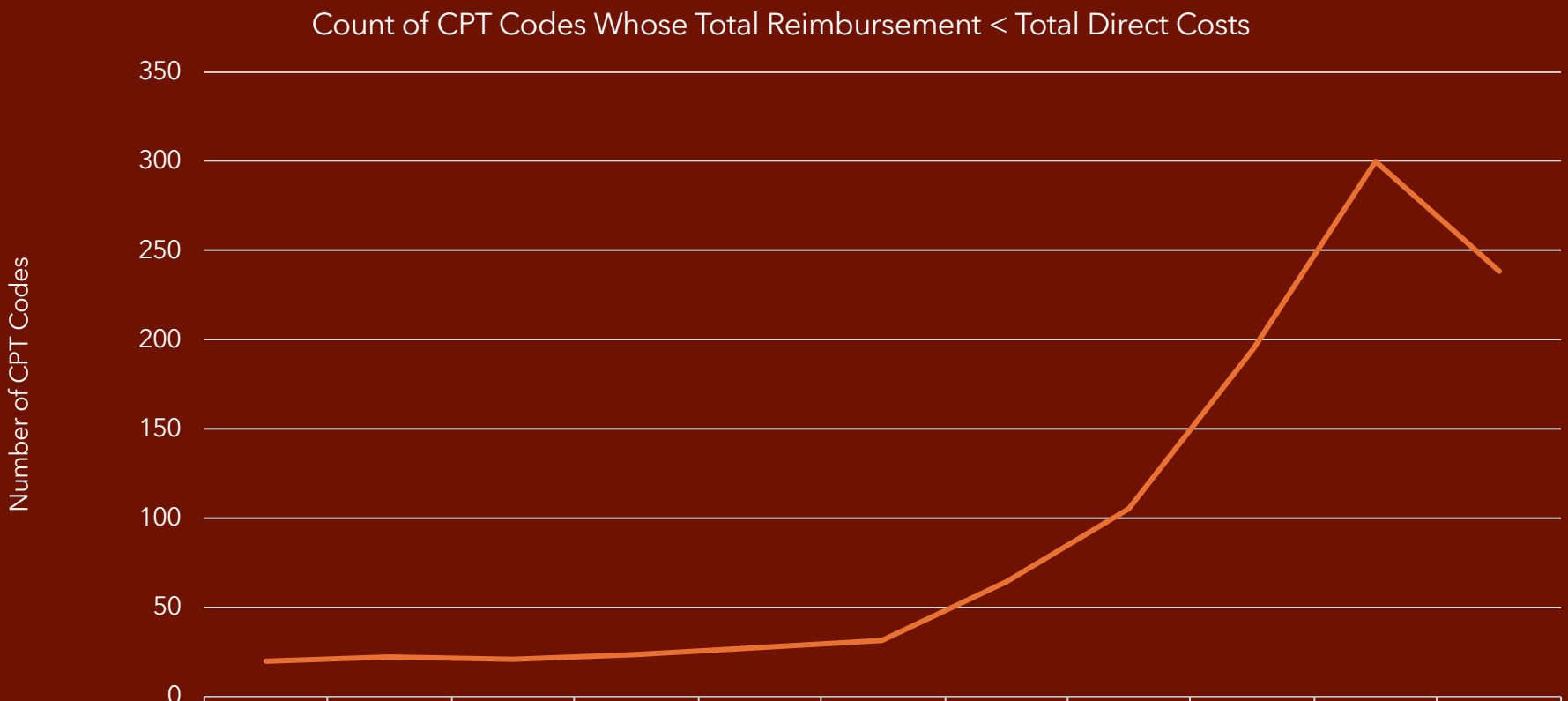
IPE Policy is a Step in the Right Direction

Since 2021, the number of CPT codes whose total reimbursement is less than their CMS calculated direct costs has aggressively increased each year. The Indirect Practice Expense policy in the 2026 PFS Final Rule is an important step in the right direct, but additional actions must be taken to address this problem on a permanent basis.



	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
CPT Codes	20	23	21	24	28	32	64	105	195	300	239

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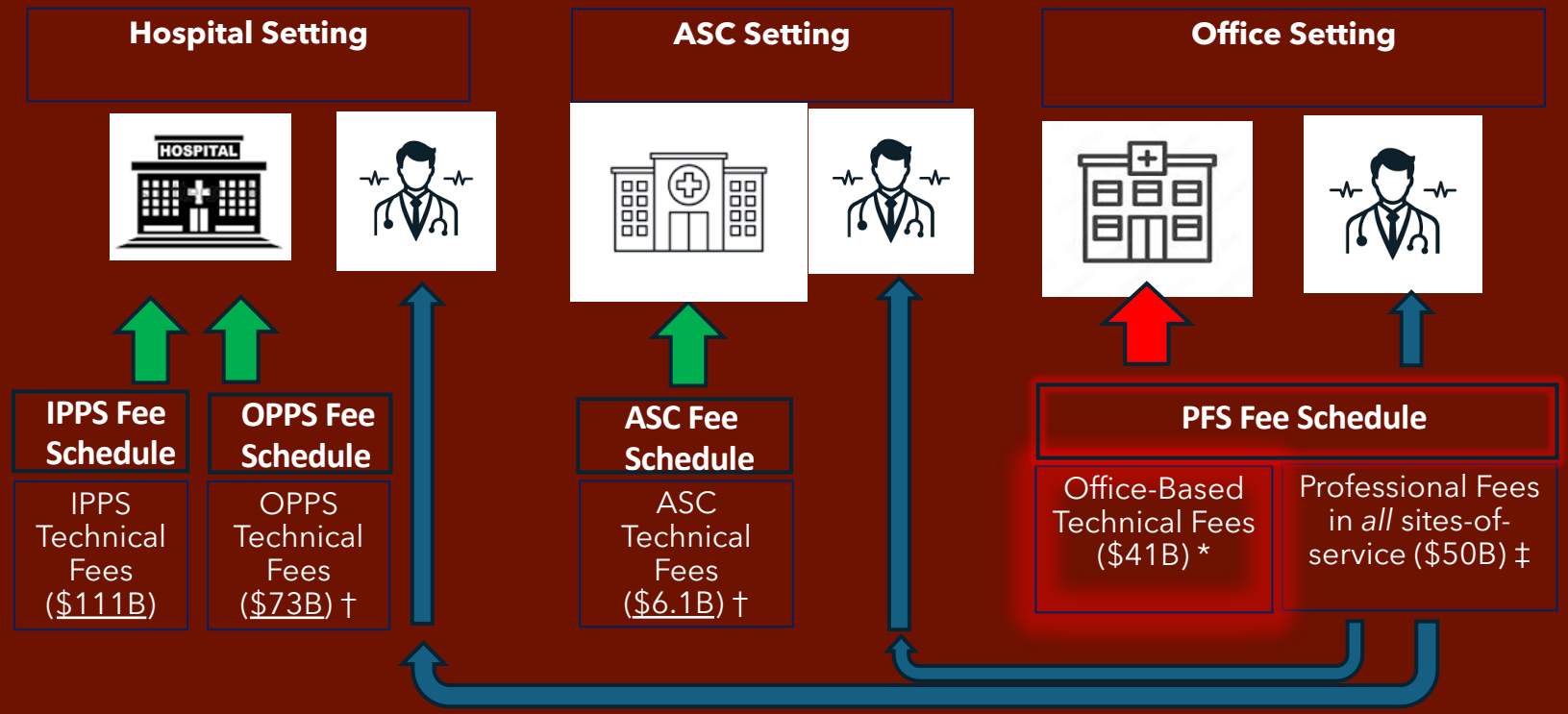
So what's the remaining problem?

- 2024 Cureus article: *The Physician Fee Schedule Was Not Built for High-Cost Supplies and Equipment*
    - "[W]hen Medicare established the PFS in 1992, policymakers did not anticipate that technology would advance to the point that it would allow minimally invasive endovascular care or radiation therapy to be performed in a community-based setting."
    - "[T]he migration of more high-tech, high-cost procedures to the office setting adds pressure to a system already struggling to keep pace with rising costs and inflation.
    - In other words, the Direct Expense of these procedures remains a drag on the physician fee schedule

Fundamental PFS Reform: Removing Practice Expense from the PFS

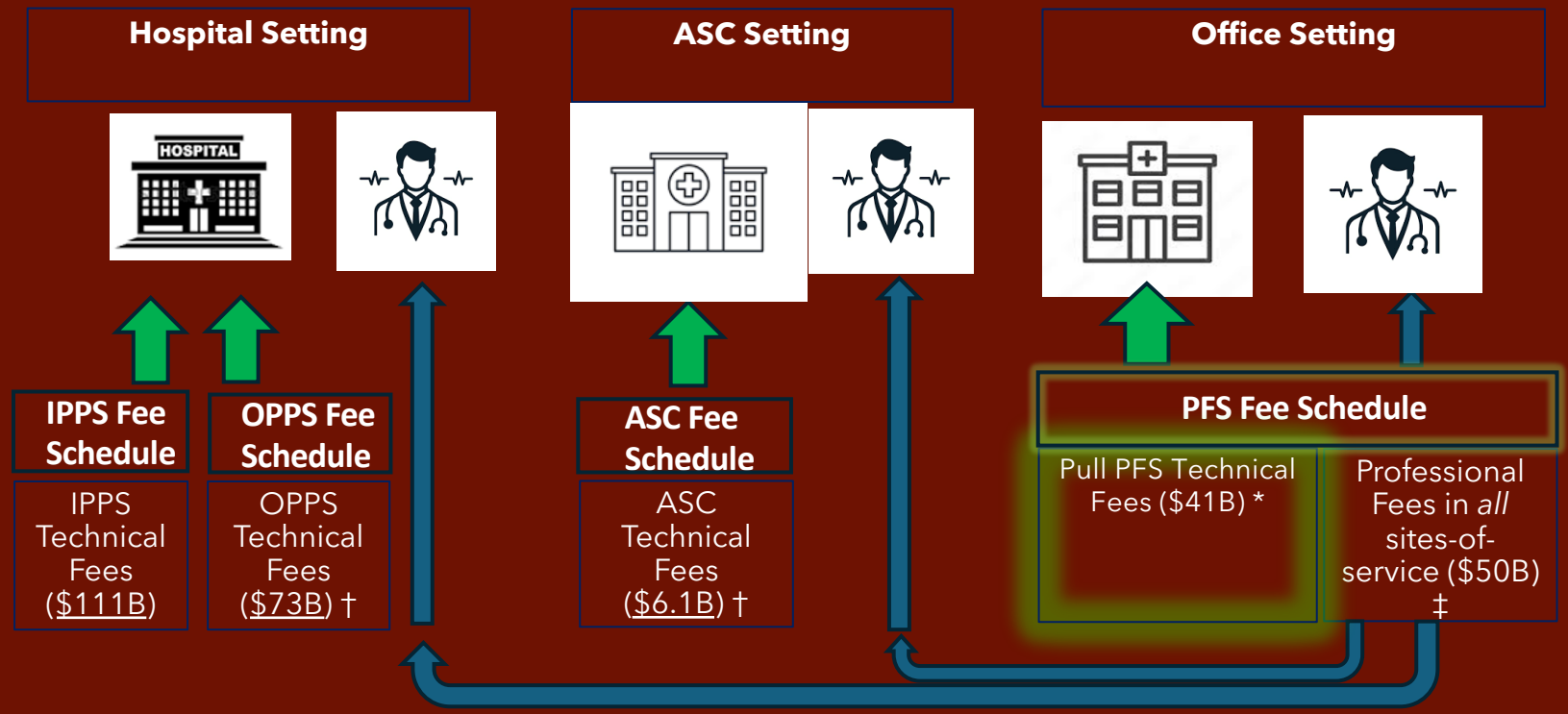
- **Fundamental PFS Reform: Paying for Practice Expense Outside of the PFS**
  - In the 2026 PFS Final Rule, CMS requested comments relating to linking services (limb salvage, radiation treatment delivery, superficial radiation therapy, proton therapy) to OPPS rates.
  - Congress should link all office-based supplies and equipment to OPPS rates by *removing* office-based practice expense from the PFS altogether.

Unlike Other Medicare Fee Schedules, Reimbursement for Office-Based Practice Expense (or Technical Fees) Flow Through the Physician Fee Schedule



† The OPPS Fee Schedule and the ASC PPS Fee Schedule are released as a single, consolidated OPPS / ASC Fee Schedule as part of annual CMS rulemaking.
‡ This includes compensation for the physicians, therapists, and advanced practice providers for the work they do as well as for related malpractice insurance.
* This includes all medical supplies (e.g. $3,000 drug-coated balloons), equipment (e.g. $3 million linear accelerators), and clinical labor used in the office-based setting. $91 billion number for total PFS professional ($50B) and technical payments ($41B) is based off the 2026 PFS Proposed Rule.

Paying for Technical Fees Outside of the PFS Would Rationalize PFS Technical Payments with Other Fee Schedules and Leave the PFS for Professional Fees



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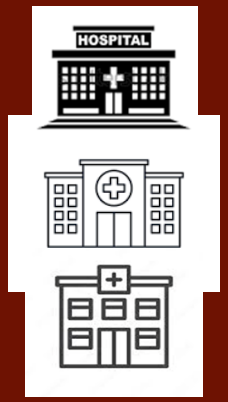
Congress Should Create a New Office-Based Facility Fee Schedule Which Would Handle Office-Based Technical Costs and Be Based on OPPS Data

Medicare Professional Fee Schedule

Reformed Physician Fee Schedule would focus on Professional Fees:
Physicians (and allied professionals) and related malpractice insurance ($50B)†



Medicare Technical Fee Schedules ‡

Hospital Fee Schedules	ASC Fee Schedule	New Office-Based Facility Fee Schedule
IPPS Fee Schedule Technical Fees ($111B)	ASC PPS Fee Schedule Technical Fees ($6.1B)	Office Based Facility Fee Schedule Technical Fees ($41B) *
OPPS Fee Schedule Technical Fees ($73B) †		

† Office-based technical payments would remain in the PFS for services that have no corresponding OPPS payment rates.
‡The new OBF Fee Schedule would be released as part of the current annual OPPS Fee Schedule / ASC PPS Fee Schedule.
* High-cost medical supplies (e.g. $3,000 drug-coated balloons) and equipment (e.g. $3 million linear accelerators) used in the office-based setting instead would be reimbursed as part of a consolidated OPPS / ASC / OBF Fee Schedule.

Benefits of Removing Practice Expense from the PFS

Stops Dilution of the Physician Fee Schedule So it Can Focus on Physician Pay

- PFS would no longer be subsiding the OPPS as new minimally invasive, high-cost technologies flow to the office-based setting without OPPS dollars following them.
- Allows "Physician Fee Schedule" to focus on "physician fees," (i.e. work), rather than unrelated high-cost supplies and equipment.

Allows for Regular Collection of Reliable Practice Expense Data For Office Setting

- Taking supplies and equipment out of the PFS and using OPPS data to value practice expense removes AMA RUC input into PFS practice expense, which historically has been unreliable and opaque.
- Using OPPS data to value office-based services allows CMS to capture reliable practice expense data annually from a nationwide, auditable dataset (i.e. the Hospital Outpatient PPS database).

Provides for a Responsible Approach to Site-Neutrality and Stopping Consolidation

- Removing practice expense from the PFS and linking it to OPPS data is a responsible way to effectuate site-neutrality across ambulatory settings and save independent practices.
- Such an approach aligns payments across multiple sites of service to include office-based practice expense in the OPPS / ASC methodology and prevents growing site of service discrepancies.

Preserves Lowest-Cost Office-Based Care, Particularly in Rural Areas

- Establishing an "Office-Based Facility" site-of-service linked to the OPPS fee schedule captures office-based efficiencies while ensuring such office-based care has stability and predictability.
- Office-based centers are needed in rural and underserved areas where ASCs and rural hospitals are not typically present (e.g. due to CON, cost considerations) and where significant specialty deserts exist.

Upcoming Legislation

- **H.R. 7863, Promoting Fairness for Medicare Providers Act**
  - Payment would be established at 90% of ASC rates using an ASC-like payment methodology through an **OBF** Fee Schedule.
  - Procedures in this new "Office-Based Facility" site of service would include surgical procedures with supply items greater than $500, consistent with AMA recommendation.
  - High-cost supply services would be paid outside of the PFS.

Thank you for your attention!

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