Society of Gynecologic Oncology

230 W. Monroe St., Ste. 710
Chicago, IL 60606-4703 USA
main: 312.235.4060
fax: 312.235.4059

September 12, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via Regulations.gov

Re: CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1832-P)

Dear Administrator Oz,

The Society of Gynecologic Oncology (SGO) appreciates the opportunity to review and provide comments on the Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) proposed rule for CY 2026. We appreciate this opportunity as it is vital to ensure the fee schedule supports Medicare beneficiaries' access to medically necessary care, while providing adequate payment for the services provided by our members.

The SGO is the premier medical specialty society for healthcare professionals trained in the comprehensive management of gynecologic cancers. Our more than 3,000 members include physicians, advanced practice providers, nurses, and patient advocates who collaborate with the SGO's foundation, the Foundation for Women's Cancer, to increase awareness of gynecologic cancers and improve the care of those diagnosed with gynecologic cancers. Our mission focuses on supporting research, disseminating knowledge, raising the standards of practice in the prevention and treatment of gynecologic malignancies, and collaborating with other organizations dedicated to gynecologic cancers and related fields, all with the ultimate vision of eradicating gynecologic cancers.

The SGO submits comments on the following topics:

- Conversion Factor Update
- Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential
- Proposed Efficiency Adjustment
- Strategies for Improving Global Surgery Payment Accuracy

Conversion Factor Update

2026 marks the first year that there are two statutorily mandated conversion factors: one for practitioners working in a qualifying advanced alternative payment model (APM) and the other for those not participating in a qualifying APM. The conversion factor for the former will increase to $33.59, an increase of 3.83%, and the conversion factor for the latter will increase to $33.42, an increase of 3.62%.

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We understand that an act of Congress is required to provide regular updates to the MPFS' conversion factor, and the SGO appreciates the update provided by Congress in the recent reconciliation package for CY 2026. However, without a permanent solution to fix annual payment updates the cycle of uncertainty will continue to plague our members each year, contributing to anxiety and burnout. A stable payment system with annual inflationary updates to the conversion factor is needed to alleviate uncertainty, and to maintain confidence among the physicians that participate in Medicare.

Additionally, the payment cuts proposed in this rule, namely the efficiency adjustment and payment for indirect practice expense in the facility further undermine physician confidence in the payment system. At a time when our members are treating more complex patients with chronic conditions, like obesity, cutting payment because of perceived efficiency is not going to help an already beleaguered physician workforce. We encourage the agency to reconsider the proposed policies that negate the positive conversion factor update approved by Congress.

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential
CMS proposes to change the methodology for the allocation of indirect practice expenses (PE) within the physician payment formula. As described in the rule CMS proposes "for each service valued in the facility setting under the PFS, we propose to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to nonfacility PE RVUs beginning in CY 2026." According to the agency, this proposed change reflects the current state of clinical practice given that there are fewer physicians working in private practice settings, and therefore, "*the allocation of indirect costs for PE RVUs in the facility setting at the same rate as the non-facility setting may no longer reflect contemporary clinical practice*."

The SGO disagrees with the CMS assumption that indirect practice expenses are not incurred for physicians who are providing services in the facility setting. Both independent and hospital-employed physicians face these costs, as our members report instances where hospitals often allocate expenses such as administrative staff, billing, and scheduling back to the physician departments thus reducing physician compensation. While practice consolidation does occur for reasons such as increased financial stability, access to capital, and assistance with ever increasing regulatory burdens, cutting physician payment is not a reasonable or evidenced-based response to address consolidation issues.

Reducing the indirect PE component of the physician payment formula without clear, evidence-based justification is not a reasonable solution to address CMS' stated concerns about consolidation. The SGO believes that such cuts are likely to worsen consolidation by applying continued downward pressure on physician reimbursement. This policy will not increase the availability of physicians, including specialists like gynecologic oncologists, in office-based community settings.

Also, the proposed 50% reduction to the indirect PE portion of the formula appears arbitrary and unsupported. CMS has not shared the underlying data or methodology, leaving stakeholders unable to appropriately evaluate the proposed policy or provide meaningful feedback. Some of our members report wide variation in facility-based expenses, some incur

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costs such as rent, billing, and scheduling staff, while others do not. Because these costs are inconsistent across settings, a sweeping, one-size-fits-all payment cut could unfairly disadvantage many physicians. Rather, CMS should work with medical specialty societies to develop fair and appropriate payment policy.

We oppose CMS' proposed cut to the indirect practice expense portion of services performed in the facility setting and urge the agency to NOT finalize this proposal. Instead, CMS should pursue policies that accurately reflect resource costs across all practice settings. Physicians, regardless of the site of service, continue to bear indirect practice expenses, and further reductions will erode both practice stability and the value of the services delivered to patients. At a minimum, if CMS proceeds despite these concerns, the agency should phase in any changes and subsequent payment cuts over four years, consistent with previous practice expense methodologic changes, to help mitigate unnecessary financial disruption to physician practices.

Strategies for Improving Global Surgery Payment Accuracy:
CMS is considering next steps to improve the valuation and payment of global surgery services, including approaches to establish the payment allocations for portions of the global package when the transfer of care modifier (modifier -54) is used. The agency is considering approaches to specifically use information reported to CMS on the number and level of post-operative visits to improve the global surgical service valuation. CMS also requests comments on strategies to improve the accuracy of payment for global surgical packages.

The SGO remains concerned with CMS's conclusion that physicians are not performing post-operative care for their surgical patients and that the value of post-operative care is inappropriately captured within the MPFS. The SGO has previously provided detailed comments on the valuable care that our members provide to Medicare beneficiaries during the global surgical period. To provide this valuable, sometimes lifesaving post-operative care, gynecologic oncologists must see their patients more often than what is valued into the global surgical package. For example, when caring for patients with ovarian cancer, our members often manage delayed healing after advanced surgery or address the poor healing that can occur following a radical hysterectomy in a smoker with cervical cancer—all care that takes place within the global period. Similarly, during the postoperative period following laparoscopic hysterectomy for endometrial cancer, our members counsel patients on the importance of continuing colon and breast cancer screening as part of long-term survivorship care. There are critical discussions that take place in the weeks immediately following the pathologic diagnosis and these discussions and E/M visits (often requiring more post-operative visits that are in valued into the procedure) demand substantial time from physicians and their teams to deliver comprehensive patient education.

To prove this, the SGO Coding and Reimbursement Committee conducted a data collection project to better understand how gynecologic oncologists provide post-operative care. Members of the Committee reviewed chart notes for eight commonly performed 90-day global surgical procedures used to treat gynecologic cancers and tallied the number of E/M services (inpatient and outpatient) that were provided per patient. Nine of our subcommittee members reviewed a total of sixty-four charts. While this data is anecdotal, we were able to determine that the physicians who participated in the data collection effort provided more post-operative E/Ms than are included in the global surgical package for the procedures of

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interest. Additionally, in general, the level of the E/M provided post-operatively was at a higher level than level valued into the service.

The SGO does not support revisions to the surgical global package, and instead we reiterate our comments submitted for the 2025 MPFS proposed rule: We recommend the agency use well-established processes for valuing services under the MPFS, including identifying services that may be misvalued. If there are surgical services that the agency believes are indeed misvalued, including the number and type of post-operative visits valued in the service, the agency should follow the process of nominating the service as misvalued, and allow the RUC and the specialty societies to assist with revaluation. The SGO would welcome the opportunity to meet with the agency to discuss the global surgical package issue, and we are available should the agency have questions about the valuable care we provide to our patients during the post-operative period.

Proposed Efficiency Adjustment:
For the first time, CMS proposes an efficiency adjustment to reduce the work RVUs and intraservice physician times for non-time-based services, effectively reducing reimbursement based on the rationale that physicians who perform these services get more efficient over time.

Specifically, CMS proposes to apply an efficiency adjustment of -2.5% to the work RVUs and intraservice time for nearly all services on the MPFS including procedures, radiology services, and diagnostic tests. The adjustment would not apply to time-based services, including evaluation and management (E/M) visits, behavioral health services, maternity global codes, and care management services. If applied indefinitely, however, this adjustment, introduced without evidence to support the policy, would compound year after year, driving reimbursement downward. To our knowledge, the MPFS has never incorporated an ongoing productivity adjustment to work RVUs and intraservice time, and applying one without evidence that efficiencies continue indefinitely is methodologically unsound and risks systematically undervaluing physician services. Physician work cannot be assumed to become perpetually more efficient without eroding the accuracy and fairness of the fee schedule.

The SGO opposes this proposal and urges the agency not to finalize this policy. This is an arbitrary policy created by the agency that cuts payment and undermines the valuable care gynecologic oncologists provide to Medicare beneficiaries. This highly technical and valuable care includes the diagnosis and surgical management of cancerous and noncancerous conditions of the female reproductive system, including conditions like cervical cancer, endometriosis, fibroids, ovarian cancer, pelvic masses, uterine cancer, vaginal cancer, and vulvar cancer.

Procedure Efficiency:
The agency is using a flawed assumption to justify an efficiency adjustment by assuming that physicians become more efficient over time due to technological advances and experience gained through the repetition of surgical procedures. We call your attention to a recently published study in the Journal of the American College of Surgeons, which found that the proposed efficiency adjustment is not supported by empirical surgical time data. Intra-service time data (i.e., skin-to-skin operative time) from 2019 and 2023 were compared for 1.7 million surgeries across 249 CPT codes and eleven surgical specialties from the National Surgical

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Quality Program registry. The study concluded that "*Overall, operative times* ***increased by 3.1 percent*** *(CI 3.0-3.3%, p<0.001) in 2023 compared to 2019, or 0.8 percent/year (CI 0.7-0.8%/year, p<0.001). At the procedure level, 90 percent of CPT codes had longer or similar operative times in 2023 compared to 2019.*"

We agree that there may be some efficiency gains to some procedures over time, but efficiency gains through physician experience and repetition of a procedure are often lost due to several factors out of the physician's control. Patient complexity, such as obesity, diabetes, hypertension, and other chronic conditions, increases surgical complexity and duration. For example, operating on patients with obesity typically requires more time and effort, and places greater physical demands on the physician, which eliminates any efficiencies gained through experience.

Efficiency gained through experience is also tempered by the gynecologic oncologist's responsibility for managing an entire operating room team. These physicians lead complex cancer surgeries, overseeing operative planning, ensuring that all necessary diagnostic studies, documentation, and consents are complete and available in the operating room, and clearly communicating the surgical plan to the team. During the procedure, the gynecologic oncologist ensures sterile technique, makes critical intraoperative decisions, and directs the flow of the operation while coordinating clinical staff and ensuring patient safety. When complications occur or equipment and technology fail, surgeons must coordinate the team's response, and these failures or complications add time and complexity to the procedure. This work extends well beyond the technical performance of surgery.

Taken together, these responsibilities demonstrate that surgeons are not only performing complex procedures but are also managing surgical teams while ensuring safe and effective care delivery. Any policy that undervalues this work by introducing an efficiency adjustment fails to recognize the amount of time and skill required to produce successful patient outcomes.

Our members note that there has been a loss of surgical support staff who had the collective, institutional knowledge required to assist with complex gynecologic oncology surgical cases. This loss of support staff, including nurses, physician assistants, surgical technicians, and others with years of experience, began during the COVID-19 pandemic when older, more experienced staff decided to retire from the profession. This has led to a dearth of specialized staff with the knowledge to provide the surgical assistance required for gynecologic oncology surgeries. Our physician members report that during surgery, they often request a specific instrument or device only to discover that support staff are unfamiliar with it, forcing surgeons to spend valuable time educating staff mid-operation, creating delays that erase any efficiency gains.

Additionally, many hospitals no longer staff operating rooms with specialized teams dedicated to the specific type of surgery being performed. We have heard from our members that they must collaborate with the surgical staff assigned to the case, even if those staff are, for example, well versed in orthopedic procedures, and not gynecologic procedures. This type of staffing model leads to longer procedure times, while again negating the physician's efficiency.

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Technology Efficiency:
The agency states in the rule "*non-time-based codes, such as codes describing procedures, radiology services, and diagnostic tests, should become more efficient as they become more common, professionals gain more experience, technology is improved, and other operational improvements (including but not limited to enhancements in procedural workflows)* are implemented."

These comments refute the assumption that procedural workflows and physician experience inherently lead to more efficient procedures, and we also disagree with the agency's assumption that the use of technology improves efficiency. It is true that there have been tremendous technological advances in the field of medicine and surgery, but using technology does not equate to efficiency. Whether the use of technology involves using a robotic device to assist in surgery or analyzing the vast amounts of medical data generated by innovative technologies, physicians must still review, analyze, interpret, and make appropriate and timely clinical decisions based on these vast amounts of data. This adds complexity and time rather than reducing it.

Our members report that "clicking through an EHR to find previous operative notes or to review patient history prior to the start of a surgical intervention is time consuming and not efficient at all." In the case of performing a medical procedure, using technology may make the procedure more precise but not necessarily more efficient. We caution the agency that it should not make assumptions about technological efficiency and instead we suggest the agency collect or provide, if it already exists, real-world data supporting the efficiency adjustment.

The SGO reiterates that CMS not to finalize this policy. Efficiency should be recognized as a hallmark of high-quality care, not penalized through payment cuts—no other profession is treated this way.

Codes Subject to the Efficiency Adjustment:
Finally, two procedure codes that are critical to SGO members are inappropriately included on the efficiency adjustment list; CPT® code 96547 (*Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure*) and 96548 (*Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure*). These two codes are time-based, as clearly indicated by their descriptors and therefore should not be subject to the efficiency adjustment policy.
Thank you for the opportunity to provide comments on the MPFS 2026 proposed rule. If you have questions or need additional information, please contact Carly Leon, Manager, Health Policy and Government Affairs: carly.leon@sgo.org.

Thank you,

Lara L MD
President, Society of Gynecologic Oncology