SVS | Society for Vascular Surgery

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September 14, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1848-P: Medicare and Medicaid Programs; CY 2027 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:

The Society for Vascular Surgery (SVS) is a professional medical specialty society, composed primarily of vascular surgeons, that seeks to advance excellence and innovation in vascular health through education, advocacy, research, and public awareness. The SVS, on behalf of its approximately 6,500 members, offers comments on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rule Making on the revisions to Medicare payment policies under the Medicare Physician Payment Schedule (MPFS) for 2027, published in the July 16, 2026, Federal Register (Vol. 91, No. 135 FR, pages 43842-44557).

Vascular surgeons care for Medicare beneficiaries across the continuum of care - from diagnosis and longitudinal medical management through open and endovascular intervention, postoperative care, and lifelong surveillance. Vascular disease is especially consequential for the Medicare population. Vascular surgeons care for patients at risk of stroke, aneurysm rupture, limb loss, dialysis-access failure, chronic wounds, and other conditions in which timely specialty evaluation and treatment can materially affect survival, function, and independence. Contemporary vascular care increasingly combines medical management, advanced imaging, open surgery, endovascular treatment, and longitudinal surveillance, often for older patients with multiple serious comorbidities.

Recent SVS research underscores both the growing need for this care and the resources required to provide it. Research presented at the 2026 Vascular Annual Meeting (VAM26), for example, documented substantial growth in referrals for peripheral artery disease (PAD) within the Department of Veterans Affairs. Other recent SVS research has examined limb-threatening ischemia, carotid revascularization, and the real-world implementation of guideline-directed PAD care. These studies reflect a specialty that is continually evaluating how to improve outcomes while caring for increasingly complex vascular disease. Society for Vascular Surgery, VAM26 Research Highlights (2026).

SVS also has a longstanding commitment to ensuring that Medicare payment policy appropriately recognizes the resources required to furnish that care. As Matthew Sideman, MD, then chair of the SVS Coding Committee, stated in discussing prior Medicare payment policy, "The SVS Coding Committee has worked and will continue to work on behalf of the SVS membership to advocate for fair and appropriate reimbursement." That principle remains relevant today. Medicare payment should reflect the physician work and practice resources required to furnish high-quality vascular care and should not rely on generalized assumptions disconnected from how services are actually provided. Vascular Specialist, CMS Finalizes 2020 Physician Fee Schedule (2019).

SVS approaches the CY 2027 proposed rule from that perspective. CMS projects a positive aggregate directional impact for vascular surgery under the combined work, PE, and malpractice RVU changes. SVS appreciates that aggregate result. The fact that vascular surgery has a positive aggregate specialty impact does not resolve whether the proposed methodology produces appropriate resource-based values for individual vascular services. CMS' supporting files permit stakeholders to examine those effects at the code level, and SVS has done so. Where that review identifies a substantial or unexpected change, SVS believes it is important to determine whether the result reflects an actual change in the resources required to furnish the service or instead results from redistribution within the proposed methodology and produces a result that may be inconsistent with the underlying resource requirements or broader Medicare policy objectives.

The comments below address the continued efficiency adjustment; proposed PE methodology changes, including their effect on AAA screening; the site-of-service payment differential; separately identifiable E/M services; global surgical packages; primary-care payment; CPT and RUC processes; and specific vascular services addressed in the proposed rule.

## SVS Comments re: CY2027 revisions to payment policies under the Medicare Physician Fee Schedule (MPFS)

### Stabilizing Payment for Physicians

Vascular surgeons, like many specialists, face unique challenges in maintaining high standards of care amid rising costs and undervalued services. The SVS is concerned that CMS' proposed policies included in the CY2027 MPFS continue to exacerbate the underlying problems within the broken Medicare physician payment system. Furthermore, these policies negatively impact the ability of physician practices to invest in quality improvement efforts that benefit Medicare patients, or transition to alternative payment models when appropriate.

Beginning in 2026, there are two separate conversion factors, one for Qualifying APM Participants (QPs) and one for non-QP clinicians. The statutory update based on the MACRA law to the qualifying APM conversion factor (which applies to PFS payments for QPs) for CY 2027 is 0.75 percent while the update to the nonqualifying APM conversion factor (which applies to PFS payments for all other clinicians) for CY 2026 is 0.25 percent. The changes to the PFS conversion factors for CY 2027 include these updates as required by statute and an estimated +0.53% adjustment necessary to account for proposed changes in work RVUs for some services. However, Public Law 119-21 provided a one-year PFS conversion factor increase of 2.50% for CY 2026, which will no longer be in effect for CY 2027. This effectively means that current law requires -2.50% reduction in Medicare payment under the PFS compared to CY 2026 as the first step in calculating the CY 2027 conversion factor.

Thus, the CY 2027 qualifying APM conversion factor represents a projected decrease of $0.40 (-1.19%) from the current conversion factor of $33.57, for a total of $33.17. Similarly, the CY 2027 nonqualifying APM conversion factor represents a projected decrease of $0.56 (-1.68%) from the current conversion factor of $33.40, for a total of $32.84.

Preliminary SVS analysis, in addition to the impact charts provided in the proposed rule by CMS indicate that the combined impact for vascular surgeons for CY2027 is +3%. However, there is a significant underlying differential based on site of service and case mix.

| TABLE D-B5: CY 2027 PFS Estimated Impact on Total Allowed Charges by Specialty | | | | | | |
|---|---|---|---|---|---|---|
| (A) | (B) | (C) | (D) | (E) | (F) | (G) |
| Specialty | Allowed Charges Non-Facility/Facility | Allowed Charges (mil) | Impact of Work RVU Changes | Impact of PE RVU Changes | Impact of MP RVU Changes | Combined Impact* |
| VASCULAR SURGERY | TOTAL | $1,015 | 0% | 3% | 0% | 3% |
| | Non-Facility | $747 | 0% | 4% | 0% | 4% |
| | Facility | $268 | 0% | 0% | 0% | 0% |

Mandating deep cuts to certain physician services for no reason other than to increase payments for other physician services is an unfair and outdated policy. This pattern is repeated year after year via the constraints of budget neutrality and other seemingly arbitrary policy proposals that significantly impact the various inputs utilized to derive payments for various physician services. The proposed payment differential for vascular surgery based on site of service differential is a prime example of the impact of such policies. Policymakers must commit to modernizing our payment systems so that physicians are freed from the "zero-sum" methodology that has been relied on for so long, which ultimately hinders team-based, coordinated care.

SVS has concerns that continued reliance on flawed methodologies across various facets of the fee schedule will measurably reduce the ability for vascular surgeons to provide critical services to vulnerable populations. Systemic issues such as the negative impact of the Medicare physician fee schedule's budget neutrality requirements and the lack of an annual inflationary update will continue to generate significant instability for health care clinicians moving forward, threatening beneficiary access to essential health care services.

Policymakers within the Administration and Congress must establish a cohesive policy development and legislative process for the advancement of long-term reforms designed to ensure a physician payment system that is predictable, fair, and sustainable. The Patients First Act (H.R. 9693), new legislation introduced with 25 bipartisan cosponsors, is the most comprehensive physician payment reform bill in more than a decade. The bill includes longstanding physician payment reform concepts as well as provisions to modernize relevant quality-related programs to ensure they are actually driving provision of high-quality care for patients. Unfortunately, there are several areas of significant policy misalignment when comparing the CY2027 MPFS Proposed Rule and the Patients First Act. This disconnect further illustrates the disconnect between lawmakers and policymakers within the Administration.

SVS believes that our policy makers, both within the Administration and in Congress, have a duty to ensure a stable physician payment environment that allows multiple physician practice models — independent private practice or hospital/health system employment — to thrive. Failure to do so will contribute to the ongoing, costly consolidations of the health care delivery system, hinder patient access to the physician of their choice, and hamper efforts to move toward safe, accountable, higher-quality care. A strong Medicare payment system should provide financial stability through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace, or revise budget neutrality requirements to allow for appropriate changes in spending growth.

*SVS Recommendation: CMS must work with Congress and applicable stakeholders to identify and advance Medicare physician payment reform policies that will provide long-term stability for physicians serving patients within the Medicare program. We urge CMS to actively engage with both Congress and the physician community to refine and advance H.R. 9693, or similar legislation, reflective of the following concepts:*

- Establishing a permanent inflationary update to the MPFS.
- Eliminating or adjusting the budget neutrality requirements within the MPFS to help ensure payment stability for physicians providing care for Medicare beneficiaries.

SVS' comments below address the continued efficiency adjustment; proposed PE methodology changes, including their effect on AAA screening; the site-of-service payment differential; separately identifiable E/M services; global surgical packages; primary-care payment; CPT and RUC processes; and specific vascular services addressed in the proposed rule.

## PHYSICIAN WORK EFFICIENCY ADJUSTMENT

### Continued Application of the Efficiency Adjustment

CMS is not proposing a new efficiency adjustment policy for CY 2027. Nevertheless, the 2.5 percent efficiency adjustment finalized for CY 2026 continues to reduce the work RVUs and corresponding intraservice time of most non-time-based surgical services. SVS continues to oppose the underlying assumption that vascular surgical work predictably becomes more efficient over time merely because economy-wide productivity increases.

SVS' concern is supported by empirical surgical data. In commenting on the CY 2026 policy, SVS highlighted research examining more than 1.7 million operations across 249 CPT codes and 11 surgical specialties. Operative times increased 3.1 percent overall between 2019 and 2023, and 90 percent of procedures had the same or longer operative times. Measures of patient complexity also increased. Christopher P. Childers, MD, PhD, et al., Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 million Operations Between 2019 and 2023, Journal of the American College of Surgeons (2025).

Vascular surgery is particularly ill suited to a generalized efficiency assumption. Technological advances have expanded endovascular options and changed patient selection, but they also permit treatment of older and more medically complex patients and can shift physician work among preoperative planning, image review, device selection, technical execution, intraoperative judgment, and longitudinal surveillance. Innovation may change where work occurs without reducing total physician work or intensity.

SVS urges CMS to reconsider the efficiency adjustment and not treat its continued application as evidence that affected vascular services have become less resource intensive. Changes in physician work should be supported by service-specific clinical and empirical evidence.

## PRACTICE EXPENSE METHODOLOGY

### Step 8 Indirect Practice Expense Allocator

CMS proposes revising Step 8 so that indirect PE is allocated using the sum of work RVUs and the clinical labor portion of direct PE RVUs for many services, while excluding 10- and 90-day global services. SVS supports efforts to improve PE accuracy but is concerned about substantial redistribution when multiple components of the PE formula change simultaneously. CMS has not provided sufficient code- and specialty-level information to isolate the independent effects of the proposed utilization changes, indirect allocator change, IPCI phase-out, and stabilization adjustment. SVS urges CMS to postpone implementation of these interrelated PE methodology changes until the Agency publishes sufficiently granular analyses for stakeholders to understand the independent and cumulative effects of each proposal. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, Practice Expense methodology discussion.

SVS is also concerned that CMS proposes to exclude 10- and 90-day global services from the revised indirect allocator even though the RAND analysis underlying the sum methodology did not exclude global codes. SVS urges CMS to apply the sum of work RVUs and clinical labor RVUs methodology consistently to 10- and 90-day global services. If CMS retains the exclusion, it should provide a resource-based explanation for departing from the methodology evaluated by RAND.

### Phase-Out of the Indirect Practice Cost Index

SVS supports CMS's proposal to phase out the Indirect Practice Cost Index (IPCI). The existing specialty-level adjustment relies on dated PE per hour data and can affect individual services based on broad specialty-level characteristics rather than the resources associated with the services themselves. CMS estimates that the proposed PE methodology changes will have a positive aggregate effect on vascular surgery, and SVS supports movement toward a methodology that more accurately reflects service-level resources. CMS should nevertheless provide sufficient code-level information to allow stakeholders to understand the source of individual changes and monitor the methodology as it is implemented.

### Practice Expense Stabilization Adjustment

SVS supports the concept of a stabilization adjustment that limits abrupt annual changes in PE RVUs while CMS transitions to a substantially revised methodology. A stabilizer can reduce short-term volatility, but it does not resolve an underlying methodological problem if the fully implemented PE values do not accurately reflect resource costs. This concern is particularly important for specialties facing substantial negative directional effects from the proposed PE changes.

CMS has previously used multi-year transitions when implementing significant changes to the PE methodology. For example, CMS phased in the bottom-up PE methodology over four years beginning in CY 2007 and subsequently used a four-year transition when incorporating specialty-specific PE per hour data from the Physician Practice Information Survey beginning in CY 2010. Centers for Medicare & Medicaid Services, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, 71 Fed. Reg. 69624 (Dec. 1, 2006); Centers for Medicare & Medicaid Services, Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010, 74 Fed. Reg. 61738 (Nov. 25, 2009).

Given the number of interrelated PE changes proposed for CY 2027, SVS recommends a four-year transition for significant adverse effects resulting from the revised methodology, consistent with CMS precedent. The transition should not unnecessarily delay increases where the revised methodology demonstrates that current PE values understate resource costs. CMS should also publish the fully implemented values and the independent effect of each major PE policy so stakeholders can understand both the transition and the ultimate methodology.

Abdominal Aortic Aneurysm Screening - CPT Code 76706

SVS' review of CMS' code-level supporting files identified CPT code 76706 as a service for which the proposed PE methodology produces a concerning reduction. CPT code 76706 describes the Medicare screening ultrasound for abdominal aortic aneurysm (AAA). The resources required to furnish the screening service have not changed, and CMS is not proposing a code-specific change to the service's physician work, clinical description, or direct PE inputs. Rather, the reduction results from application of the broader proposed PE methodology.

AAA screening is a Medicare preventive service intended to identify a potentially fatal vascular condition before rupture occurs. AAA frequently remains asymptomatic until enlargement or rupture, and early identification permits surveillance, risk-factor management, referral, and elective treatment when appropriate. SVS clinical practice guidelines recommend ultrasound as the preferred screening modality and include a strong, high-quality-evidence recommendation for one-time screening in men and women ages 65 through 75 with a history of tobacco use. Society for Vascular Surgery, The Care of Patients with an Abdominal Aortic Aneurysm: Clinical Practice Guidelines of the Society for Vascular Surgery, Journal of Vascular Surgery (2018). Medicare likewise recognizes the importance of early detection by covering a once-in-a-lifetime AAA screening ultrasound for eligible at-risk beneficiaries. CMS also updated its claims-processing instructions for CPT code 76706 in 2026 to align diagnosis coding with Medicare's AAA preventive-service policy. Centers for Medicare & Medicaid Services, Medicare Claims Processing Manual, Pub. 100-04, Chapter 18, Section 110.3.2, Ultrasound Screening for Abdominal Aortic Aneurysms. The CY 2027 AAA reimbursement reduction is a result from the broader PE allocation methodology and is a good example of an unintended consequence of broad PE changes.

Site of Service Payment Differential

SVS continues to oppose the CY 2026 policy reducing by 50 percent the work RVU component used to allocate indirect PE for facility services. Site of service alone does not establish which entity bears the indirect costs associated with furnishing and reporting a vascular service. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, Updates to Practice Expense Methodology - Site of Service Payment Differential.

The 2024 AMA Physician Practice Benchmark Survey found that 77.1 percent of independent surgical subspecialists provide weekly patient care in both facility and non-facility settings. A vascular surgeon may perform an open or endovascular intervention in a hospital, evaluate patients and furnish office-based vascular procedures in a non-facility setting, and provide postoperative or longitudinal surveillance through the same practice infrastructure. Carol K. Kane, PhD, American Medical Association, Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties (2025).

A facility service does not eliminate practice costs for scheduling, coding and billing, patient communications, compliance, information technology, personnel, professional liability administration, and other resources. If CMS believes duplicative payment exists, it should identify and quantify the specific duplicated resources rather than assume a uniform reduction.

If CMS considers an alternative based on employment or contractual arrangements, the policy should apply at the individual service or claim level, not globally to a physician. Employment status itself is not a resource measure. Contracted groups, faculty practices, professional corporations, joint ventures, leased arrangements, and health-system-affiliated practices may divide overhead responsibilities differently.

CMS also seeks comment on a new HCPCS modifier for hospital- or health-system-employed physicians. If pursued, the modifier should identify an arrangement rather than automatically trigger a predetermined PE reduction.

CMS' experience implementing the CY 2026 policy illustrates why the Agency should determine actual resource costs before relying on a categorical proxy. CMS acknowledges an unintended nursing-facility payment differential based on Medicare Part A versus Part B status even though professional resource costs would not be expected to change on that basis.

CMS also acknowledges stakeholder concerns that facility PE reductions may increase financial pressure on independent physician practices and contribute to hospital acquisition and consolidation. A policy that reduces payment based on an assumed practice arrangement can make that arrangement increasingly difficult to sustain, thereby reinforcing the consolidation CMS then observes.

SVS therefore urges CMS to repeal the CY 2026 50-percent facility indirect PE adjustment. At minimum, CMS should not further reduce facility indirect PE - including to zero - without empirical evidence identifying specific duplicated resources and supporting the magnitude of the reduction.

## ACCOUNTING FOR OVERLAP BETWEEN STAND-ALONE E/M VISITS AND GLOBAL PERIODS

### Proposed 50-Percent Reduction for Separately Identifiable E/M Services

SVS strongly opposes CMS' proposal to reduce payment by 50 percent when a separately identifiable office/outpatient E/M service is furnished on the same day as a procedure with a 0-, 10-, or 90-day global period. Modifier 25 identifies a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure.

### CMS' Prior Approach Distinguished Reporting Frequency from Resource Duplication

In CY 2017, CMS used frequent reporting of 0-day global procedures with modifier 25 as a screen to identify services for further review as potentially misvalued. Reporting frequency prompted examination; it did not establish that a fixed percentage of physician work or PE was duplicative. Centers for Medicare & Medicaid Services, CY 2017 Medicare Physician Fee Schedule Final Rule, 81 Fed. Reg. 80170, 80209 (Nov. 15, 2016).

CMS subsequently proposed a related 50-percent reduction in CY 2019 and did not finalize it. The CY 2027 proposal is broader because it extends the methodology to 10- and 90-day global periods. CMS has not demonstrated that new evidence supports the expanded policy. Centers for Medicare & Medicaid

Services, CY 2019 Medicare Physician Fee Schedule Final Rule, 83 Fed. Reg. 59638-59640 (Nov. 23, 2018).

CMS Has Previously Recognized Distinct Resources in Separately Identifiable Same-Day E/M Services
CMS has previously recognized that a separately identifiable E/M service furnished on the same day as a minor procedure may contain resources sufficiently distinct from the procedure to warrant separate payment. The fact that a patient requires both a vascular procedure and a separately identifiable E/M service during the same encounter does not establish that one-half of either service is duplicative. Centers for Medicare & Medicaid Services, CY 2021 Medicare Physician Fee Schedule Final Rule, 85 Fed. Reg. 84472 (Dec. 28, 2020).

The Proposed 50-Percent Reduction Is Not Supported by the Record
CMS characterizes additional overlap as likely. That does not establish that residual duplication exists in current PFS values, much less that it equals 50 percent. The proposed reduction applies across physician work, PE, and professional liability rather than identifying a particular element shown to overlap.

SVS Recommendation
SVS urges CMS not to finalize the proposed 50-percent payment reduction and not to expand the methodology. If CMS believes residual duplication exists for a particular vascular service, it should identify the specific physician time, clinical labor, or other resource involved and address that resource through code-specific valuation.

## COMMENT SOLICITATION ON REDESIGNING PRIMARY CARE TO MAKE AMERICA HEALTHY AGAIN

SVS supports strong, appropriately resourced primary care and prevention. SVS does not believe, however, that CMS has established a need to create a separate E/M coding or valuation structure specifically for primary care.

Vascular surgeons also furnish longitudinal care for serious and chronic conditions, including PAD, aneurysmal disease, carotid disease, venous disease, dialysis access, and surveillance after vascular intervention. Recent VAM26 research on guideline-directed PAD care further illustrates that vascular care includes longitudinal medical management and clinical decision-making as well as procedures.

The office/outpatient E/M code set is not specialty specific. If CMS identifies additional physician work or practice resources associated with longitudinal or complex care that are not currently recognized, those resources should be defined, measured, and valued transparently and should be available to any physician who furnishes the qualifying service.

SVS therefore urges CMS not to establish primary-care-specific E/M codes or payment categories without demonstrating a clinical and resource-based distinction. Appropriate investment in primary care should not depend on generalized reductions to specialty and surgical services under budget neutrality.

## GLOBAL SURGICAL PACKAGES

History and the Current RAND Approach
CMS is not proposing to change 10- and 90-day global surgical packages for CY 2027 but is seeking comment on possible future approaches. In CY 2015, CMS finalized conversion to 0-day periods, under which postoperative visits after the day of the procedure would have become separately reportable and

payable. Congress prohibited implementation through section 523 of MACRA and directed CMS to collect postoperative information. MedPAC has more recently discussed retaining global periods while lowering values based on observed postoperative services. These approaches are not equivalent. Under the previously finalized 0-day approach, medically necessary postoperative E/M services removed from the package could have been separately reported and paid using the E/M values applicable when the services were furnished. Under a retain-and-revalue approach, the physician could remain responsible for postoperative care while the value of the global package is reduced. Centers for Medicare & Medicaid Services, CY 2015 PFS Final Rule, 79 Fed. Reg. 67548, 67582-67591; Medicare Access and CHIP Reauthorization Act of 2015, § 523; Medicare Payment Advisory Commission, Report to the Congress, June 2025, Chapter 1.

The distinction is especially important because the E/M visits incorporated into 10- and 90-day global surgical packages have not been fully updated to reflect the increases made to analogous stand-alone E/M services beginning in 2021. SVS does not advocate wholesale conversion of global services to 0-day periods; that approach would create significant clinical, operational, and beneficiary consequences. But CMS should not use current postoperative utilization to reduce global surgical values while continuing to value the postoperative E/M services that remain in those packages using older relative values. Doing so would address only one side of the purported relativity problem and could further distort, rather than improve, payment accuracy.

CMS Should Address the Existing Relativity of E/M Visits Included in Global Periods

The RUC has repeatedly recommended that CMS incorporate the full increases in work, physician time, and practice expense for the office, hospital, and observation visits included in global surgical packages. SVS agrees that CMS should address this existing disparity before considering broad reductions based on postoperative visit reporting. A methodology intended to improve payment accuracy should not selectively recognize evidence that could lower global values while leaving the embedded postoperative visits below the values of analogous separately reported E/M services.

The 99024 Claims Do Not Identify the Level of the Postoperative Visit

CMS originally proposed no-pay G-codes that would have captured both the number and level of postoperative services but instead adopted CPT code 99024. CPT code 99024 identifies that a postoperative visit was reported; it does not identify the level of that visit. RAND's separate survey-based study of postoperative visit level and work examined only cataract surgery, total hip arthroplasty, and complex wound repair. None of which relate to a vascular surgery or vascular procedure. Centers for Medicare & Medicaid Services, CY 2017 PFS Final Rule, 81 Fed. Reg. 80170, 80209-80225; RAND Corporation, Survey-Based Reporting of Post-Operative Visits for Select Procedures with 10- or 90-Day Global Periods: Final Report (2019).

The RAND Arithmetic Does Not Reflect Magnitude Estimation

Global surgical work RVUs were established using magnitude estimation. Postoperative visit assumptions informed the overall magnitude estimate; they were not independently valued, severable building blocks mechanically added together to produce the final work RVU. It therefore is not appropriate to reverse that process by assigning an RVU amount to assumed postoperative visits and subtracting it from the current work RVU. More complete utilization data would not transform magnitude estimation into a building-block methodology. RAND Corporation, Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- or 90-Day Global Periods: Updated Results Using Calendar Year 2019 Data (2021).

Beneficiary Cost-Sharing and Access Must Be Considered

Conversion to 0-day global periods is not a simple alternative. Routine postoperative care currently included in a global package is not separately billed to the beneficiary. Conversion would make postoperative visits separately reportable and payable, with corresponding Medicare cost-sharing. CMS should consider whether separate cost-sharing at individual postoperative encounters could affect access to recommended follow-up care. Centers for Medicare & Medicaid Services, Medicare Learning Network, Global Surgery Booklet, MLN907166.

SVS urges CMS not to use the current postoperative visit data or arithmetic public-use-file values to make widespread reductions to global surgical services and not to view conversion to 0-day global periods as a ready alternative.

Postoperative Vascular Care Cannot Be Inferred from a 99024 Claim

The limitations of the 99024 data are particularly important in vascular surgery. Postoperative care after open or endovascular vascular procedures may include wound and access-site assessment, evaluation of perfusion and pulses, review of neurologic or limb symptoms, medication management, assessment for graft or device-related complications, and planning for vascular laboratory or imaging surveillance. The type and intensity of that work vary substantially across aortic, carotid, lower-extremity, dialysis-access, and venous procedures.

RAND's empirical visit-level study examined cataract surgery, total hip arthroplasty, and complex wound repair. None was a vascular surgical procedure. CMS therefore should not infer the level or intensity of postoperative vascular work from those three services or from the mere presence or absence of a 99024 claim.

SVS' own quality infrastructure reinforces the need for clinically interpretable data. Through the Vascular Quality Initiative, vascular specialists collect and analyze detailed clinical information to improve quality, safety, effectiveness, and cost. That experience demonstrates the value of empirical data, but also why claims counts must be interpreted in the context of the underlying vascular procedure and patient. Society for Vascular Surgery, Vascular Quality Initiative.

## E/M VISIT COMPLEXITY ADD-ON CODE G2211

Proposed Transition from G2211 to MOD1

CMS proposes to replace G2211 with MOD1, which would increase the associated office/outpatient E/M payment by 16 percent rather than provide a flat add-on payment. SVS is concerned that the proposal would further complicate E/M payment and alter the distribution of additional payment across E/M levels without demonstrating that a percentage-based adjustment better reflects resource costs. CMS should explain the clinical and resource basis for the 16 percent amount and the distributional effects of the change before finalizing the proposal. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, E/M Visit Complexity Add-On.

## CURRENT PROCEDURAL TERMINOLOGY AND RUC REQUEST FOR INFORMATION

SVS appreciates the opportunity to comment on CMS' questions regarding the CPT coding system and the CPT and RUC processes. SVS agrees that these processes should continue to evolve and that there are opportunities to improve transparency, efficiency, responsiveness, accessibility, and the appropriate

use of empirical data. No coding or valuation process is perfect, and meaningful improvements should continue to be considered.

SVS believes, however, that practicing physicians must remain central to these processes. Determining whether services are clinically distinct and whether they meet the clinical criteria for a Category I code or are more appropriately identified through the Category III pathway requires meaningful input from physicians with direct knowledge of the services and their clinical application. Economists, policymakers, data scientists, and emerging technologies, including artificial intelligence, can provide important information and tools to support this work. They cannot replace the experience and judgment of physicians who actually furnish the services being described.

This is particularly important in vascular surgery, where rapid changes in technology can alter how a service is furnished without necessarily reducing its complexity or the physician resources involved. Open surgical, endovascular, hybrid, imaging-guided, and device-based approaches may address the same underlying vascular disease while requiring materially different technical skills, clinical judgment, patient selection, and practice resources. Coding decisions must be sufficiently clinically informed to distinguish these services and sufficiently flexible to accommodate continued innovation without sacrificing meaningful clinical specificity.

The same principle applies to valuation. The RUC process integrates survey information, empirical data, magnitude estimation, comparison with other services, and the clinical expertise of practicing physicians. Each can contribute important information when evaluating physician work and direct practice expense. Greater objectivity does not require choosing between data and clinical expertise. It requires using appropriate data and having clinicians who understand the service interpret what those data do - and do not - measure.

Objective Data and Clinical Interpretation Must Work Together

SVS has substantial experience with precisely this intersection of data and clinical interpretation. Through the Vascular Quality Initiative (VQI), vascular specialists collect and analyze detailed clinical information to evaluate quality, safety, effectiveness, outcomes, and cost across vascular procedures. That experience strongly supports greater use of reliable empirical information in coding and valuation. It also demonstrates the limitations of relying on data without adequate clinical context. Claims data, timestamps, utilization patterns, registry information, and other empirical sources can identify trends, test assumptions, and identify services that warrant further examination. They do not independently establish the technical difficulty of a procedure, the intensity of physician work, the clinical significance of differences among services, or whether an observed utilization pattern reflects inappropriate valuation.

That distinction is particularly important when empirical information is used as a screen for potentially misvalued services. A screen can appropriately identify a question for further examination. It should not predetermine the answer. Once a service is identified, physicians who furnish the service should participate in evaluating whether the observed data accurately represent the typical patient and service, whether changes in technology or patient selection explain the finding, and whether physician time, intensity, or direct PE actually require modification. This combination of empirical screening and clinical review is more likely to improve payment accuracy than mechanically translating a statistical finding into an RVU adjustment.

The recent restructuring of the lower extremity revascularization code family illustrates why that clinical expertise remains necessary. Contemporary lower extremity revascularization encompasses evolving combinations of anatomy, disease severity, devices, imaging, and endovascular techniques. The revised coding structure required multispecialty clinical input to determine which services were sufficiently distinct to warrant separate reporting and how related services should be organized. An administrative dataset can show how frequently a service is reported; it cannot independently determine how contemporary vascular interventions should be clinically differentiated.

SVS therefore supports continued efforts to improve the RUC process, including greater transparency and appropriate independent validation of survey and other resource inputs. Objective information should be used to test and validate recommendations where reliable data are available. At the same time, the limitations of each data source should be acknowledged. Claims data measure billed services; timestamps may measure portions of an encounter but not all physician work; cost data may identify expenditures without determining which resources are attributable to a particular professional service. No single data source should be treated as a complete substitute for a clinically informed valuation process.

Transparency and Confidentiality

Transparency is an important part of continued improvement, but it must be balanced against legitimate confidentiality concerns. Materials considered during the code development process and subsequent valuation process may include information regarding emerging devices and procedures, regulatory submissions, or other proprietary information that is not yet public. Premature disclosure can create competitive or market consequences unrelated to the merits of a coding or valuation decision. SVS supports making recommendations, supporting information, and process materials more accessible when appropriate while preserving confidentiality where there is a legitimate need for it. Increased transparency and appropriate confidentiality protections are not mutually exclusive.

No Existing Alternative Is a Workable Substitute for CPT

SVS also urges CMS to carefully consider the practical implications of replacing CPT. At present, there does not appear to be another established coding system capable of replacing CPT as the national standard for reporting physician and other professional services. ICD-10-PCS, SNOMED CT, MS-DRGs, OPPS APCs, and other coding, terminology, or payment systems perform important functions, but those functions are different and are not readily interchangeable with CPT's role in describing professional services.

CPT is deeply embedded throughout Medicare, Medicaid, commercial payer systems, physician practices, health information technology, contracts, quality measurement, research, and other healthcare infrastructure. A fundamentally different coding framework would therefore require much more than creation of a new list of codes. It would require mapping, testing, implementation across payers and health information systems, education of physicians and other users, revision of contracts and payment systems, and mechanisms for maintaining clinical specificity as medicine evolves. CMS should not undertake a transition of that magnitude unless an alternative has been fully developed, tested, and demonstrated to provide meaningful advantages over the existing system.

SVS therefore generally supports continued use and improvement of the existing CPT and RUC processes. Modernization should include better use of objective data and new technologies, appropriate validation of resource inputs, and continued progress toward greater transparency. Those improvements

should strengthen - not displace - the role of practicing physicians in determining how medical services are clinically described and how the resources required to furnish them should be evaluated.

## TREATMENT OF INCOMPETENT VEINS

### CPT Code 36466

CMS proposes to accept the RUC-recommended work RVUs for CPT codes 36465, 36470, 36471, 36473, and 36474 and the RUC-recommended direct PE inputs for all six services in the incompetent-vein family. SVS supports those proposals. For CPT code 36466, however, CMS proposes a work RVU of 2.62 rather than the RUC-recommended 2.93, based on a crosswalk to CPT code 57156 and the decrease in surveyed physician time. SVS urges CMS to accept the RUC-recommended work RVU of 2.93. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, Treatment of Incompetent Veins.

The change in surveyed physician time for CPT code 36466 should not be interpreted as evidence that the service has become less complex or less intense. The current survey and the prior survey did not describe the same typical patient. The earlier vignette identified incompetence of the great and small saphenous veins but described treatment of the great saphenous and anterior accessory saphenous veins. The current vignette corrects that inconsistency and describes treatment of the great and small saphenous veins, which more accurately represents the typical patient for the service.

SVS also disagrees with CMS' proposed use of CPT code 57156 as the basis for a work RVU of 2.62. CPT code 57156 describes insertion of a vaginal radiation after loading apparatus for clinical brachytherapy and is not clinically comparable to ultrasound-guided intravascular treatment of multiple incompetent truncal veins. The services differ substantially in anatomy, procedural technique, imaging requirements, physician decision-making, and risk. CPT code 36466 requires ultrasound-guided vascular access and treatment of multiple incompetent veins and carries clinically significant risks, including hemorrhage, deep vein thrombosis, and pulmonary embolism.

Physician work is not determined by time alone. Under the resource-based PFS, work also reflects the technical skill and physical effort required, mental effort and judgment, and psychological stress associated with risk to the patient. The RUC recommendation reflects consideration of these components of physician work and maintains appropriate relativity within the incompetent-vein family. CMS has not demonstrated that the reduction in surveyed time establishes a proportional reduction in total physician work, nor has it identified a clinically appropriate basis for substituting CPT code 57156 for the RUC's specialty-informed valuation.

SVS therefore urges CMS to accept the RUC-recommended work RVU of 2.93 for CPT code 36466 and maintain appropriate relativity within the incompetent-vein code family.

## MEDIAN ARCUATE LIGAMENT RELEASE

### CPT Codes 39XX1 and 39XX2

CMS proposes to accept the RUC-recommended direct PE inputs for the new open and laparoscopic median arcuate ligament release services but applies the previously finalized efficiency adjustment to the RUC-recommended work RVUs, resulting in proposed work RVUs below the RUC recommendations. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, Division of Median Arcuate Ligament.

SVS recommends that CMS value CPT codes 39XX1 and 39XX2 at the RUC-recommended work RVUs without applying a generalized efficiency reduction. These are new services whose physician work was

recently surveyed and evaluated through the valuation process. CMS has not demonstrated that the physician time or intensity required for these specific procedures is reduced by the economy-wide productivity assumption underlying the efficiency adjustment.

## USE OF EMPIRICAL DATA TO IDENTIFY POTENTIALLY MISVALUED SERVICES

### Deleted Lower Extremity Revascularization Codes

CMS seeks comment on a potentially misvalued-code nomination that relies on claims and other empirical data to question physician time for several surgical services, including former CPT codes 37227 and 37229. Those vascular codes were deleted effective January 1, 2026, as part of the comprehensive restructuring of the lower extremity revascularization (LER) code family and therefore do not provide an appropriate basis for evaluating the valuation of current LER services. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, Request for Revaluation of Physician Work Time Based on Empiric Data.

SVS is concerned about the broader implications of using this type of analysis to identify current vascular services for revaluation. Claims-based analyses that sum PFS-assigned physician times across services may be useful as a screening tool, but they should not be treated as direct empirical measurements of physician time or work. This concern is especially important because CPT codes 37227 and 37229 were deleted effective January 1, 2026, as part of a comprehensive multispecialty restructuring of the LER code family. Findings derived from the deleted codes should not be carried forward mechanically to a newly defined family that reflects a different coding structure and contemporary clinical practice.

SVS has extensive experience using empirical clinical data through the Vascular Quality Initiative and supports data-driven review when the data are clinically interpretable and relevant to the service being valued. Any future review of the new LER services should use utilization and other evidence generated under the current coding structure, explain how claims-based findings relate to the typical service, and include code-specific clinical review.

SVS therefore urges CMS not to extrapolate findings involving deleted CPT codes 37227 and 37229 to the newly established LER code family. If CMS later identifies current LER services for review, the Agency should use contemporary data and evaluate those services on their own clinical and coding terms.

## PHYSICIAN-PATIENT COUNSELING REGARDING CLINICAL TRIAL PARTICIPATION

### Potential New HCPCS G-Code

CMS is seeking comment on whether to establish a new HCPCS G-code to recognize physician or other qualified health care professional counseling of patients who are considering or participating in clinical trials. SVS supports the concept of appropriately recognizing substantial physician work associated with clinical trial counseling. Clinical trials play an important role in vascular surgery, including evaluation of new devices, technologies, and approaches to treatment of arterial and venous disease. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, Physician-Patient Counseling Regarding Clinical Trial Participation.

Discussions regarding clinical-trial participation may require the vascular surgeon to explain the patient's underlying vascular disease, available treatment alternatives, trial eligibility, and the potential risks and benefits of investigational and established treatment options. SVS recommends that CMS clearly define when the new service may be reported and how it interacts with existing E/M services and research funding. Medicare payment should not replace costs appropriately borne by a clinical-trial sponsor, but

clinically necessary counseling and shared decision-making furnished by the treating physician should be recognized when not otherwise included in payment for another service.

Clinical-trial counseling is particularly relevant in vascular surgery because vascular surgeon-investigators participate in research involving limb ischemia, carotid disease, aortic disease, venous disease, dialysis access, and new devices and technologies. For some patients, the treating vascular surgeon is uniquely positioned to explain how an investigational option compares with open surgery, endovascular treatment, or medical management and how trial participation fits within the patient's longitudinal vascular care. Society for Vascular Surgery, Clinical Research and Vascular Research Initiatives Conference (2026).

### DUPLICATE IMAGING AND RESULT-SHARING REQUEST FOR INFORMATION

#### Clinically Necessary Repeat Vascular Imaging Must Be Protected

SVS supports efforts to improve interoperability and reduce truly unnecessary duplicate testing. Repeat vascular imaging, however, should not be presumed duplicative based solely on the type of test or the interval between services. Vascular disease often requires longitudinal surveillance and repeat duplex ultrasound or other imaging may be clinically necessary to assess disease progression, evaluate a bypass graft or endovascular intervention, investigate new or changing symptoms, or examine a different vascular territory. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, Request for Information on Duplicate Testing and Result Sharing.

SVS would be concerned about claims edits, frequency limits, or payment reductions that do not adequately distinguish unnecessary duplication from clinically appropriate surveillance and reassessment. Any future policy should include clear clinical exceptions, account for changes in patient condition and prior interventions, and recognize that prior images may not always be available, complete, or clinically adequate. CMS should prioritize interoperable exchange of vascular imaging and reports rather than place physicians at financial risk when repeat testing is medically necessary.

### MEDICARE TELEHEALTH SERVICES

#### Continued Telehealth Flexibility

SVS supports continued access to Medicare telehealth services when clinically appropriate. Telehealth can facilitate follow-up and access to subspecialty expertise, but it should complement rather than replace in-person care when vascular examination, physiologic testing, imaging, or the patient's clinical condition requires an in-person encounter. SVS supports maintaining clinician flexibility to determine the appropriate modality based on the needs of the individual patient. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, Payment for Medicare Telehealth Services.

## Comments on the CY 2027 Medicare Physician Fee Schedule Proposed Rule Quality Payment Program (QPP): Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs)

The SVS supports CMS's continued transition to MIPS Value Pathways (MVPs), supports expansion of MVP participation to Virtual Groups, and generally supports simplifying reporting requirements. However, SVS recommends that CMS strengthen the proposed MIPS Core Measure framework by formally engaging MVP Stewards in measure selection and ensuring Core Measures remain clinically meaningful and representative of specialty care.

Sunsetting Traditional MIPS Reporting

SVS appreciates CMS approving and maintaining the Vascular Surgery MVP and understand that with the current number of MVPs available, more physicians who are participating in MIPS will have access to an MVP for CY 2027 for reporting purposes. However, we believe CMS' proposal to retire the traditional MIPS reporting pathway following the CY 2028 performance period is premature.

Expansion of MVP Participation to Virtual Groups

SVS supports permitting Virtual Groups to participate in MVP reporting beginning with the CY 2029 performance period. Increased participation will improve benchmarking, strengthen the validity of performance data, and encourage adoption of specialty-specific quality measures. We also support CMS's phased implementation timeline to allow refinement of participation requirements.

MIPS Core Measures

SVS supports CMS' proposal to eliminate the requirement that physicians must report one outcome or high-priority measure to satisfactorily meet the quality category requirements, and to remove the outcome/high-priority measure designation. With the limited number of meaningful outcome measures available in the MVPs and in the MIPS program, the requirement has been a challenge for practices to meet.

SVS appreciates CMS' goal of promoting consistency across MVPs and while the concept of a standardized Core Measure requirement is better than having to report an outcomes measure. The primary purpose of MVPs is to measure specialty-specific quality. Standardization should not diminish clinical relevance, particularly if the CMS selected Core Measures are not specialty specific. For vascular surgery, relying on a single Core Measure that every vascular surgeon who participates in the Vascular Surgery MVP has to report, does not help with the adoption of the use of MVPs for MIPS reporting.

SVS strongly recommends that CMS establish a formal process for MVP Steward review and concurrence before designating, removing, or materially modifying Core Measures within an established specialty MVP. Core Measure selection should reflect clinical relevance, measure validity and reliability within the specialty population, feasibility, and the ability of the measure to meaningfully differentiate quality Core Measures should assess care that is reasonably attributable to the reporting clinician. Vascular surgeons should not be held accountable for measures primarily dependent on care delivered by other clinicians, health systems, or services outside the vascular surgeon's reasonable control. SVS would recommend the following vascular-specific measures for consideration as the Vascular Surgery MVP Core Measure requirement:

- Quality Measure 344 – Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)
- Quality Measure 226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Quality Measure 259 – Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #2)

- Quality Measure 438 – Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- Low-Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management (under development)

New Quality Measure for Public Comment

SVS supports CMS's proposal to add the **Low-Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management** measure to the MIPS Quality Measure Inventory.

This measure complements **Quality Measure 438 – Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**, which is currently included in the Vascular Surgery MVP. Together, these measures evaluate both the appropriate prescription of statin therapy and the achievement of evidence-based lipid management goals. The relationship between these measures directly impacts vascular outcomes and provides a more comprehensive assessment of the quality of vascular care delivered to patients.

SVS recommends finalizing this measure for inclusion in the MIPS Quality Measure Inventory. SVS further recommends incorporating the measure into the **Vascular Surgery MVP** to strengthen assessment of evidence-based vascular risk reduction and improve quality measurement for the vascular specialty.
SVS supports CMS's proposed update to the **Hospital-Wide 30-Day Unplanned Readmission Rate for MIPS Groups** measure, specifically the removal of the denominator exclusion for patients with a principal or secondary diagnosis of COVID-19 coded as present on admission (POA) on the index admission claim.

The COVID-19 public health emergency has ended, and clinical management has evolved substantially since the measure exclusion was originally implemented. Removing this temporary exclusion will restore consistency in measure specifications and improve the comparability of performance results across MIPS Groups. SVS supports finalizing this proposal as it reflects current clinical practice and maintains the integrity of the readmission measure while simplifying measure specifications.

Removal of Anticoagulant Management Improvement Activity

SVS acknowledges CMS's rationale for proposing removal of the Anticoagulant Management Improvement Activity, recognizing that the existing activity is primarily based on warfarin management and does not fully reflect the evolution of contemporary anticoagulation therapy.
However, SVS does not support removing this Improvement Activity at this time. Appropriate anticoagulation management remains a fundamental component of vascular patient care and directly contributes to patient safety, prevention of thrombotic complications, and overall quality of care. Currently, there is no comparable improvement activity or quality measure within the MIPS inventory that broadly addresses anticoagulation management.
SVS recommends retaining the Anticoagulant Management Improvement Activity until a clinically relevant replacement addressing contemporary anticoagulation management has been developed and is available for implementation.

New Improvement Activity for Public Comment

SVS supports CMS's proposal to add IA_CC_XX – Care Coordination: Use of Data to Improve Practice Workflows to the MIPS Improvement Activity Inventory.
The proposed activity encourages development and maintenance of evidence-based algorithms, clinical pathways, processes, and order sets grounded in established clinical practice guidelines and peer-

reviewed literature. Standardized clinical workflows promote consistency in care delivery, improve care coordination, and facilitate implementation of current evidence-based practices.

SVS believes this Improvement Activity aligns with CMS's goals of reducing unwarranted variation in care while encouraging continuous quality improvement through data-driven practice redesign.

SVS recommends finalizing this Improvement Activity to encourage broader adoption of evidence-based clinical workflows across vascular practices.

SVS supports the addition of IA_CC_XX: Understand and Improve Diagnostic Performance. Efforts to reduce delayed, inaccurate, and missed diagnoses and improve communication of diagnostic information are important to patient safety and quality of care. This activity also supports diagnostic transparency, staff competency, and the completeness and accuracy of patient information.

SVS supports this activity because it promotes interdisciplinary collaboration, patient safety, and patient-centered care.

SVS supports the addition of IA_AHW_XX: Systematic Screening and Intervention for Nutrition and Other Health-Impacting, Non-Clinical Issues. Standardized approaches to identifying nutrition needs, housing instability, transportation barriers, financial strain, and other non-clinical factors can help clinicians identify barriers that may affect patients' ability to access and adhere to recommended care.

SVS supports this activity because it strengthens care coordination and facilitates a more comprehensive approach to patient care. CMS should provide sufficient flexibility for practices to implement this activity based on available resources and community services and should avoid requirements that create additional documentation burden.

SVS supports the addition of IA_AHW_XX: Advance Care Planning Conversations to Support Patient Wellness and Care Preferences. Structured discussions with patients and caregivers regarding advance care planning, end-of-life preferences, and palliative care options support informed decision-making and help ensure that treatment decisions reflect patients' goals and preferences.

SVS supports this activity because it promotes care coordination, shared decision-making, and patient-centered outcomes.

SVS supports the addition of IA_AHW_XX: Lifestyle Approaches to Diabetes Remediation. Evidence-based lifestyle interventions are an important component of diabetes management and can support improved outcomes for patients with chronic disease, including patients with vascular disease.

SVS supports this activity because it promotes prevention, wellness, and whole-person care.

SVS supports the proposed Improvement Activities and recommends that CMS finalize their inclusion in the MIPS Improvement Activities inventory and incorporating it into the Vascular Surgery MVP. Collectively, these activities support patient safety, care coordination, interdisciplinary collaboration, shared decision-making, and whole-person care. CMS should maintain flexibility in how clinicians satisfy these activities and ensure that participation does not create duplicative documentation or unnecessary administrative burden.

Modification of Scoring for Topped Out MIPS Core Measures

SVS supports CMS's proposal to eliminate the automatic 7-point scoring cap for MIPS Core Measures that remain topped out for a second or subsequent consecutive performance year.

Smaller specialty-focused disciplines have a limited inventory of applicable quality measures compared with larger primary care specialties. As clinical performance improves, these measures are naturally more likely to become topped out. Because specialty quality measure development requires substantial clinical expertise, resources, testing, and maintenance, smaller specialties often lack the capacity to continuously develop replacement measures.

Maintaining an automatic scoring limitation for topped out measures may unintentionally penalize specialties for sustained high-quality performance rather than encouraging continued excellence in patient care. Topped-out status alone should not be used as a basis for removing a clinically important specialty measure when the measure continues to assess an important aspect of care and no suitable replacement measure is available.

SVS recommends finalizing this proposal and allowing topped out Core Measures to receive full achievement points based on established benchmarks. This approach more accurately reflects clinician performance while recognizing the unique challenges faced by specialty measure stewards.

Promoting Interoperability Program Modifications

SVS supports CMS's proposed modifications to the Promoting Interoperability performance category, including aligning the definition of Certified Electronic Health Record Technology (CEHRT) with the ONC HTI-5 proposed rule, making the Electronic Prior Authorization measure optional for the CY 2027 performance period and awarding 10 bonus points to physicians who attest “Yes,” and imposing no scoring consequence on physicians who do not report the measure,, removing the Security Risk Analysis measure, and updating the Electronic Prior Authorization measure requirements for future performance periods.

These proposals appropriately reduce unnecessary administrative burden while maintaining the functionality needed to support coordinated, high-quality patient care. Simplifying reporting requirements allows clinicians and practices to devote more time and resources to direct patient care while continuing to advance meaningful use of health information technology.

SVS recommends finalizing these proposals to streamline Promoting Interoperability reporting, reduce unnecessary burden on clinicians, and provide practices with sufficient time to implement evolving interoperability requirements.

Removal of Two Measures from the APP Plus Measure Set

SVS supports CMS' proposal to remove the two identified measures from the APP Plus Measure Set. Removal is appropriate as CMS continues transitioning quality reporting toward electronic clinical quality measures (eCQMs). Retiring measures that will be replaced or superseded through electronic reporting can reduce duplicative reporting requirements and support a more streamlined transition to electronically derived quality measurement.

Addition of Electronic Clinical Quality Measures to the APP Plus Measure Set

SVS supports CMS's proposal to add electronic clinical quality measures (eCQMs) to the APP Plus Measure Set. This approach is consistent with CMS's broader transition toward electronic quality measurement across its quality reporting programs and supports preparation for the eventual adoption of digital quality measures (dQMs).

Expanding the use of eCQMs within the APP Plus Measure Set can facilitate greater standardization and interoperability of quality data while reducing reliance on manual data collection and reporting. SVS encourages CMS to continue aligning eCQM implementation requirements across programs and to provide sufficient implementation timelines and technical guidance to support clinicians, practices, and accountable care organizations as CMS advances toward digital quality measurement.

Applicable Percentage for Qualifying APM Participants

CMS identifies the applicable percentage for the indicated payment years as follows:

- **2019 through 2024:** 5 percent
- **2025:** 3.5 percent
- **2026:** 1.88 percent
- **2028:** 3.1 percent

SVS supports the continued availability of an incentive payment for eligible providers participating in Advanced Alternative Payment Models (APMs). Financial incentives recognize the additional investment, administrative responsibilities, and accountability associated with participation in value-based payment arrangements.

Any positive incentive provides value to participating clinicians and can help encourage continued engagement in Advanced APMs. SVS therefore supports maintaining the applicable percentage and encourages CMS to work with Congress to preserve meaningful financial incentives for physicians who participate in qualifying value-based payment models.

FHIR RFI

*Transition Approach and Design*

**What factors should be considered in determining the structure of the 2-year transition period, during which FHIR-based reporting options and existing electronic quality reporting options for CQMs and eCQMs would be available concurrently?**

SVS supports a phased transition to FHIR-based quality measurement and reporting but recommends that CMS provide sufficient time, technical assistance, and resources to measure stewards and reporting entities throughout implementation. Measure stewards will require time to evaluate existing measures, convert applicable measures to FHIR-based specifications, conduct testing, and determine whether the converted measures continue to produce valid and reliable results.

The financial and technical resources required for FHIR conversion may be substantial and potentially cost-prohibitive, particularly for specialty societies and other measure stewards with limited measure-

development resources. CMS should consider providing technical and financial resources to support conversion and avoid creating circumstances in which clinically valuable specialty measures are discontinued solely because their stewards cannot absorb the costs of FHIR conversion.

This consideration is particularly important for measures included in MIPS Value Pathways (MVPs). The loss of specialty-specific measures because of technical conversion requirements could diminish the clinical relevance of established MVPs and reduce meaningful measurement options for specialists.

SVS recommends that the transition includes a defined **run-in period** during which FHIR-based measures operate concurrently with existing reporting methods. This period should allow CMS, measure stewards, vendors, and clinicians to evaluate data accuracy, measure performance, feasibility, reliability, and unintended consequences before FHIR-based reporting becomes mandatory or affects payment.

Scoring During the Transition Period

**What are the scoring implications that CMS must consider during the transition period, when multiple reporting options are available?**

SVS recommends that the transition to FHIR-based reporting be **scoring neutral until the efficacy and comparability of the new reporting methodology have been established**. Differences in scores resulting from reporting methodology, technology readiness, implementation challenges, or data transmission should not disadvantage clinicians.

CMS should evaluate whether FHIR-based and existing reporting methods produce comparable performance results before incorporating FHIR-based reporting into payment determinations. Clinicians should not experience lower quality scores or payment adjustments because of technical differences associated with the transition rather than actual differences in the quality of care delivered.

Data Submission, Completeness, and Regulatory Requirements

**How should CMS approach data submission criteria, completeness, and other regulatory elements around quality measurement during the transition period?**

SVS recommends flexibility in data submission, completeness thresholds, and related regulatory requirements during the transition period. Clinicians should not be penalized for deficiencies attributable to FHIR implementation, measure conversion, EHR functionality, vendor readiness, or other technical factors outside their direct control.

Clinicians are end users of these systems and are not responsible for developing FHIR standards, converting measure specifications, or ensuring that EHR and intermediary systems can successfully transmit FHIR-based quality data. CMS should establish appropriate safeguards so that implementation deficiencies attributable to measure developers, EHR vendors, QCDRs, qualified registries, or other health IT entities do not adversely affect clinician performance scores or payment.

CMS should also use the transition period to evaluate data completeness and identify systematic differences between existing reporting mechanisms and FHIR-based reporting before establishing permanent regulatory thresholds.

Factors Affecting Readiness for FHIR-Based Reporting

**How does readiness for adopting FHIR-based quality measurement and reporting vary across different practice types, organizational settings, and supporting health IT entities, including EHR vendors, QCDRs, qualified registries, and other intermediaries?**

Readiness for FHIR-based reporting will vary considerably across practices and health IT entities. Implementation will depend substantially on the capabilities and readiness of EHR vendors, QCDRs, qualified registries, and other intermediaries supporting quality reporting.

CMS should ensure that EHR vendors and other health IT entities have demonstrated FHIR capability before clinicians are required to rely exclusively on FHIR-based reporting. Vendors should also provide practices with adequate education, implementation support, testing opportunities, and clear information regarding system requirements.

Smaller, independent, rural, and specialty practices may have fewer technical and financial resources available to implement new reporting requirements. CMS should therefore evaluate readiness across different practice environments and avoid establishing mandatory implementation timelines based primarily on the capabilities of large health systems or organizations with substantial health IT infrastructure.

SVS recommends that CMS establish clear readiness criteria for measure stewards, EHR vendors, QCDRs, qualified registries, and other intermediaries before transitioning from concurrent reporting to mandatory FHIR-based reporting. **The transition should be driven by demonstrated technical readiness and validated measure performance rather than by a predetermined implementation date alone.**

SVS further recommends that CMS **recruit and conduct beta testing with voluntary pilot sites before any broader rollout of mandatory FHIR-based reporting.** Pilot testing should occur independently of the formal quality reporting cycle so that participation and testing results do not affect a clinician's or practice's actual quality reporting, MIPS performance score, or Medicare reimbursement/payment adjustment. Separating beta testing from the reporting cycle would allow CMS, measure stewards, vendors, and participating practices to identify and resolve technical, operational, data completeness, measure calculation, and workflow issues without creating unintended financial consequences for clinicians.

Pilot sites should be sufficiently diverse to evaluate the feasibility and reliability of FHIR-based reporting across the range of settings in which clinicians practice. CMS should ensure representation of **rural and urban practices; individual clinicians and group practices; institutional and non-institutional settings; different geographic regions; and a representative range of EHR vendors and reporting intermediaries.** Testing across these environments is necessary to identify variations in interoperability, data availability, workflow, implementation burden, and measure performance that may not be apparent in a limited or homogeneous testing environment.

CMS should use the results of this beta-testing period to establish and validate objective readiness criteria before proceeding to mandatory implementation. A transition to required FHIR-based reporting should occur only after pilot testing demonstrates that the reporting infrastructure can reliably support

accurate measure calculation, complete data submission, consistent performance results, and feasible implementation across diverse practice settings.

MSSP RFI

Meaningful Specialist Engagement

SVS recommends that CMS improve specialists' access to timely, actionable, and specialty-specific performance information. Performance data should reflect the services furnished by the specialist and should be available at sufficient intervals during the performance year to allow clinicians and ACOs to identify performance gaps and undertake quality improvement activities before the close of the performance period.

CMS should also modify beneficiary assignment policies to appropriately recognize specialty care while maintaining the central role of primary care. Assignment methodologies should incorporate specialty-specific HCPCS and CPT codes when those services more accurately identify the clinician or entity responsible for management of a beneficiary's condition or episode of care. CMS should also clarify how specialty attribution would interact with disease- or condition-specific Innovation Center models and ensure that overlapping models do not result in duplicative or conflicting attribution requirements.

Participation in specialty-specific clinical registries and structured quality improvement programs should be recognized as evidence of meaningful specialist engagement. The SVS Vascular Quality Initiative (VQI), for example, collects clinically detailed vascular data and provides tools that allow clinicians and centers to evaluate quality, safety, effectiveness, outcomes, and resource utilization.

Specialty registry infrastructure can support risk stratification, outcomes analysis, comparative performance assessment, identification of best practices, quality improvement, comparative effectiveness research, and more efficient use of healthcare resources. Such infrastructure can also facilitate collaboration among specialty societies, regulatory agencies, payers, manufacturers, clinicians, and other stakeholders.

CMS should therefore recognize participation in established specialty quality improvement programs as a meaningful mechanism for specialists to contribute to ACO's cost and quality objectives.

Primary and Specialty Care Integration

CMS should support standards-based, FHIR-enabled exchange of clinical and performance information among ACOs, specialists, primary care clinicians, electronic health record systems, QCDRs, and other qualified data intermediaries.

Interoperability requirements within the Shared Savings Program should align with Promoting Interoperability requirements used within the Quality Payment Program to reduce duplication and establish a consistent federal framework for electronic information exchange.

CMS should also encourage care delivery models that promote shared management of patients, including co-management arrangements, e-consults, structured referral pathways, and other mechanisms that improve communication between primary and specialty care.

Financial and Non-Financial Incentives

CMS should align specialist engagement incentives with MIPS Value Pathways (MVPs), Improvement Activities, and other Quality Payment Program requirements so that participation in ACO quality improvement activities can satisfy related federal requirements without duplicative reporting.

CMS should also recognize continuing certification activities that are directly linked to measurable quality improvement. Specialty societies and accreditation organizations can provide established infrastructure for physician engagement in improvement activities and can help align professional development with ACO quality priorities.

Financial incentives should be meaningful and sufficient to recognize the resources required for data collection, reporting, care coordination, and quality improvement. Non-financial incentives may supplement this structure but are unlikely to support sustained specialist participation when practices must absorb substantial administrative and operational costs.

To the extent permitted by statute, CMS should align Shared Savings Program financial incentives with Advanced Alternative Payment Model incentive structures so that specialists face consistent incentives across value-based payment programs.

Specialist Engagement Across ACO Types

Specialist engagement may differ substantially between high-revenue and low-revenue ACOs and between employed and contracted specialists. CMS should recognize these differences when developing participation requirements and technical assistance.

Vascular specialists frequently provide longitudinal management for beneficiaries with chronic and progressive vascular disease in addition to procedural and episodic care. Specialists participating in clinical registries, MVPs, and structured quality improvement initiatives may therefore be particularly well positioned to contribute to cost management, quality improvement, and care coordination. CMS should ensure that specialists who provide longitudinal management of chronic conditions, including vascular disease, are appropriately eligible for such payment when they meet applicable requirements. Eligibility should reflect the clinician's actual role in longitudinal disease management rather than specialty designation alone.

CMS should engage specialty societies in the development and implementation of policies designed to improve specialist participation within ACOs.

CMS-Delivered Data and Tools

CMS should provide specialty-specific performance reports that translate administrative and clinical information into actionable feedback for ACOs and specialists. Reports should be sufficiently current to permit intervention during the performance year and should be available at least quarterly where feasible.

CMS should leverage the expertise and infrastructure of specialty societies with established quality improvement programs. Specialty societies can assist clinicians and ACOs in translating performance information into meaningful improvement activities through clinical registries, educational programs, quality improvement toolkits, dashboards, and specialty-specific technical assistance.

CMS should establish a formal mechanism for specialty society participation in the development, testing, governance, and evaluation of specialty care data tools, including representation on relevant technical and advisory committees.

While the standards of care should remain consistent across high- and low-revenue ACOs, CMS should recognize differences in reporting capacity. Smaller, rural, and resource-limited organizations may require additional technical assistance and appropriate regulatory flexibility.

CMS should support implementation through webinars, written technical guidance, individualized assistance, and structured collaboration with specialty societies and other organizations that maintain established quality improvement programs.

Attribution and Assignment

CMS should incorporate specialty-specific diagnosis, procedure, and service codes into assignment methodologies when needed to identify beneficiaries receiving high-acuity or longitudinal specialty care.

Assignment and risk adjustment policies should also account for beneficiaries who enter specialty care through emergency or urgent episodes and who may not have an established primary care relationship at the time of treatment.

When specialists serve as a beneficiary's principal longitudinal clinician for a specific disease or condition, CMS should consider using episode-based service and procedure codes to appropriately recognize that role.

CMS should also develop mechanisms through which specialists can share accountability for quality and cost without being designated the beneficiary's primary clinician. Episode-based accountability models could pair specialty cost measures with clinically related quality measures so that efficiency is evaluated without creating incentives to withhold medically necessary care.

For vascular care, CMS could consider episodes involving lower-extremity revascularization for chronic limb-threatening ischemia or peripheral artery disease as potential candidates for paired cost and quality measurement, subject to appropriate testing, risk adjustment, and stakeholder review.

CMS should also consider a care coordination measure applicable to clinicians participating in management of an attributed condition or episode. Such a measure should clearly define the responsibilities of each clinician and avoid duplicative accountability.

Accounting for Care Delivered by Nurse Practitioners and Physician Assistants in ACO Assignment Methodologies

**CMS Question:** Across ACO types, such as low-revenue and high-revenue ACOs, how can CMS account for care delivered by nurse practitioners (NPs) and physician assistants (PAs) in assignment methodologies, and what role does NP/PA-led care play in supporting beneficiary attribution, recognizing that section 1899(c)(1) of the Social Security Act requires CMS to assign beneficiaries to a Shared Savings Program ACO based on their utilization of primary care services furnished by physicians and, for applicable performance years, primary care services furnished by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)?

Response:

The Society for Vascular Surgery (SVS) recommends that CMS develop mechanisms within the Medicare Shared Savings Program (MSSP), consistent with the statutory requirements of section 1899(c)(1) of the Social Security Act, to more fully recognize care furnished by nurse practitioners (NPs) and physician assistants (PAs) when evaluating beneficiary relationships with ACOs and the engagement of specialty care teams.

NPs and PAs provide a substantial proportion of longitudinal vascular care. Their responsibilities include, but are not limited to, surveillance and follow-up for peripheral artery disease (PAD), chronic limb-threatening ischemia, carotid disease, venous disease, aneurysmal disease, aortic syndromes, dialysis access, vascular trauma, thoracic outlet syndrome, access-site and device complications, and graft or endograft infections. NPs and PAs also routinely provide postoperative follow-up, wound and limb-preservation care, imaging review, referral management, and coordination of transitions between hospitals, primary care clinicians, and other specialists.

Importantly, vascular NPs and PAs frequently manage cardiovascular risk factors that influence both clinical outcomes and future utilization, including lipid management, smoking cessation, antiplatelet and anticoagulation therapy, blood pressure control, weight management, and glucose control. In many vascular practices, these clinicians serve as the principal care-coordination contact and may have more frequent longitudinal interactions with beneficiaries than the vascular surgeon.

Accordingly, an assignment methodology based solely on encounters with physicians may not fully reflect how contemporary team-based specialty care is delivered. Failure to recognize NP- and PA-furnished services risks underrepresenting the clinical relationship between beneficiaries and vascular specialty teams and, consequently, the contribution of those teams to care coordination, quality outcomes, avoidance of preventable utilization, and total cost of care.

SVS recognizes that section 1899(c)(1) establishes statutory parameters governing beneficiary assignment to Shared Savings Program ACOs. Within those statutory parameters, CMS should consider whether NP- and PA-furnished services can be incorporated as **supplemental indicators of beneficiary engagement and continuity of care**, even where such services cannot independently establish assignment. For example, CMS could consider NP/PA encounters when assessing the intensity, frequency, and longitudinal nature of a beneficiary's relationship with an ACO participant or specialty care team. Such an approach could complement, rather than replace, the physician and applicable FQHC/RHC primary care services upon which statutory assignment is based.

CMS should also consider NP/PA-delivered care when developing methodologies for identifying **meaningful specialist engagement within an ACO**. Claims for NP/PA services furnished as part of a vascular specialty practice could be linked, where feasible, to the associated ACO participant, specialty practice, or vascular care team. This would provide CMS with a more complete representation of the resources involved in managing beneficiaries with complex vascular disease and would avoid attributing the outcomes and costs of team-based care exclusively to physician encounters.

Recognition of NP/PA care is particularly important in the context of the vascular surgery workforce. Silvestre et al. projected that vascular surgeon supply will remain approximately **5,790 full-time equivalents (FTEs) between 2024 and 2037**, while demand will increase from approximately **7,860 to 9,000 FTEs**. Consequently, vascular surgery workforce adequacy is projected to decline from **73.7**

percent in 2024 to 64.3 percent in 2037, with the estimated shortage increasing from approximately 2,070 to 3,210 vascular surgeon FTEs. The same analysis identifies increasing demand for vascular surgical services as a major contributor to the widening workforce gap. As demand increasingly exceeds vascular surgeon capacity, NPs and PAs will likely assume an even greater role in longitudinal disease management, surveillance, postoperative care, risk-factor modification, and care coordination.

This issue may be particularly consequential for low-revenue, rural, and geographically underserved ACOs, where access to vascular surgeons and other specialists may be limited and team-based models may be necessary to maintain access to longitudinal specialty care. Assignment and specialist-engagement methodologies that fail to recognize NP/PA encounters could disproportionately understate the care infrastructure supporting beneficiaries in these settings.

SVS therefore recommends that CMS:

1. Preserve compliance with section 1899(c)(1) by maintaining the statutorily required primary care service basis for beneficiary assignment.
2. Recognize NP- and PA-furnished services as supplemental evidence of beneficiary engagement, continuity, and longitudinal care when evaluating beneficiary relationships with ACO participants.
3. Include NP/PA encounters when assessing specialist engagement and specialty care integration within ACOs, particularly when the NP or PA is practicing as part of an identifiable specialty care team.
4. Develop claims-based approaches for associating NP/PA services with the relevant ACO participant or specialty practice, where technically and legally feasible, so that team-based care is appropriately represented.
5. Evaluate the effects of these methodologies across low-revenue, high-revenue, rural, and other ACO types to ensure that assignment policies do not inadvertently disadvantage organizations that rely more heavily on team-based models of care.
6. Recognize the growing importance of NPs and PAs in specialty care workforce planning, particularly in specialties such as vascular surgery where projected demand substantially exceeds physician workforce capacity.

Recognition of NP- and PA-led care does not require replacing the statutory foundation for MSSP beneficiary assignment. Rather, CMS has an opportunity to ensure that its methodologies more accurately reflect the team-based nature of contemporary care delivery. Incorporating NP/PA encounters into measures of beneficiary engagement and specialist participation would provide a more complete representation of the clinicians responsible for managing complex vascular disease and would better align MSSP methodology with the goals of coordinated care, improved quality, and responsible management of total cost of care.

### Reference

Silvestre J, et al. Trends in supply, demand, and workforce adequacy in vascular surgery: Forecasting a national shortage. *Journal of Vascular Surgery*. 2025;82(3):1066-1072. doi:10.1016/j.jvs.2025.04.071.

Specialty-Specific Benchmarking

Specialty-specific benchmarks should complement, rather than replace, ACO's total cost-of-care benchmark.

CMS should define specialty benchmarking populations using validated combinations of diagnosis, procedure, place-of-service, and other administrative codes that identify clinically coherent conditions and episodes of care. These definitions should be developed with meaningful specialty society input and tested to ensure that they accurately identify the intended patient population.

Risk adjustment for specialty-specific benchmarks should incorporate validated clinical and administrative indicators of patient complexity, including comorbidities, disease severity, urgency of presentation, prior procedures, functional status when available, and other factors outside the clinician's control.

CMS could consider existing MIPS episode-based cost measure methodologies as a starting point for developing specialty-specific benchmarks, provided that specialty performance is attributed transparently and appropriately reconciled with population-level ACO financial accountability.

Specialty Performance Measurement

Specialists should be assessed using measures that are directly relevant to their scope of practice and the populations they treat.

CMS should provide specialty-level performance reports comparable to information available through the Quality Payment Program Experience Report. Specialists should not be held accountable for quality measures unrelated to the care they furnish solely because another specialty, clinician, or service line within the ACO performs poorly.

CMS should provide at least annual specialty-specific performance profiles, supplemented with more frequent actionable feedback where feasible.

Performance measurement should also support disease prevention and upstream management. CMS should accelerate development and availability of clinically meaningful specialty-specific MVPs and engage MVP stewards in maintaining measures that reflect current clinical evidence, standards of care, and emerging quality priorities.

ACOs and specialists should have access to specialty-relevant metrics, including applicable MVP measures, so clinicians can understand how their decisions, outcomes, and resource use contribute to ACO quality and cost objectives.

Because MVPs remain relatively new, sufficient evidence may not yet exist to determine their effectiveness across all ACO types and specialties. CMS should continue evaluating MVP implementation using transparent data, clinician experience, and stakeholder feedback before making significant changes to their role in accountable care.

Data Collection and Reporting Burden

CMS should reduce specialty reporting burden by aligning and standardizing quality measures across federal programs to the greatest extent practicable.

Claims-based measurement should not be limited to small or rural practices when a valid and reliable measure can be calculated across a broader population. Appropriate use of claims-based measures can reduce reporting burden, improve comparability, and increase the population available for specialty performance assessment.

CMS should also promote greater collaboration among EHR vendors, measure developers, specialty societies, clinical data registries, and other intermediaries. Development of standardized specialty-specific data sets and implementation guides could reduce the need for customized data extraction and manual reporting.

Interoperability standards should be consistent throughout the Shared Savings Program, Quality Payment Program, and other CMS models so that practices are not required to meet conflicting technical or reporting requirements.

CMS should preserve appropriate flexibility for small, rural, and resource-limited specialty practices and should work with EHR vendors and reporting intermediaries to automate data submission wherever possible.

Physician and Specialist Governance

CMS should require ACOs to demonstrate meaningful physician and specialist engagement in the selection, implementation, and review of system-level quality measures and associated payment arrangements.

Documentation should demonstrate that participating clinicians receive relevant performance information, have opportunities to participate in governance and quality improvement activities, and understand the financial methodology affecting their practice.

System-level measures should be used only when the attribution methodology establishes a clear and reasonable relationship between the measured outcome and the clinicians or entities being held accountable. Measures involving longitudinal care should be recognized when a beneficiary enters the delivery system and should not hold clinicians responsible for services or outcomes outside their reasonable influence.

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The SVS appreciates the opportunity to provide comments and feedback regarding the policies included in the CY2027 Medicare Physician Fee Schedule Proposed Rule. However, and as is outlined in our comments, we remain deeply concerned with foundational instabilities within the MPFS and how these shortcomings are exacerbated by other ancillary policy updates introduced in the annual rulemaking process. The cumulative effects of conversion factor changes, budget neutrality, physician work policies, PE redistribution, the proposed same-day E/M reduction, and potential future changes to global surgical packages raise significant concerns for the sustainability of vascular surgery practices and beneficiary access to specialized care. SVS urges CMS to evaluate these policies collectively and to ensure that payment changes are supported by evidence regarding the resources required to furnish the affected services.

Nonetheless, the SVS reiterates its commitment to work with all relevant stakeholders to identify and advance reforms that will ensure the Medicare physician payment system remains on a more sustainable

and efficient path. If you have questions regarding these comments, please contact Megan Marcinko, SVS' Associate Executive Director for Public Affairs & Member Engagement. (mmarcinko@vascularsociety.org).

Sincerely,

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