September 12, 2025

Submitted electronically via: http://www.regulations.gov

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CY 2026 Physician Fee Schedule Proposed Rule

Dear Administrator Oz:

The Dialysis Vascular Access Coalition (DVAC) appreciates the opportunity to offer its comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule for the CY 2026 Physician Fee Schedule (CMS-1832-P).[1] DVAC is a coalition of entities that provide vascular access services to individuals with advanced kidney disease and End-Stage Renal Disease (ESRD). DVAC represents societies, including the American Society of Nephrology, American Society of Diagnostic and Interventional Nephrology (ASDIN) and the Renal Physicians Association (RPA); as well as provider organizations, including Arizona Kidney Disease and Hypertension Centers, Austin Kidney Associates, Azura Vascular Care, Balboa Nephrology Medical Group, Dallas Nephrology Associates, Dialysis Access Specialists, Lifeline Vascular Care, Nephrology Associates of Delaware, Nephrology Associates of Northern Illinois and Indiana, and Northwest Renal Clinic. DVAC represents the majority of the non-hospital vascular access sector.[2]

This letter offers comments and recommendations on the following issues:

- Value of Non-Hospital Dialysis Vascular Access
- Reimbursement Pressures Facing Non-Hospital Dialysis Vascular Access are Concurrent with Rise in Catheter Rates

[1] Federal Register, 90 FR 32352, 16 July 2025
[2] For more information about DVAC, please see https://www.dialysisvascularaccess.org/about

- Updates to the Indirect Practice Expense (PE) Methodology – Site of Service Payment Differential
- Use of OPPS Data to Set PFS Rates
- MIPS Value Pathways
- Undervaluation of Conversion Factor Due to G2211 Assumption
- Efficiency Adjustment

I. VALUE OF NON-HOSPITAL DIALYSIS VASCULAR ACCESS

Non-hospital vascular access centers (VACs) provide a wide variety of lifesaving, critical vascular access services for ESRD patients on dialysis. To access the patient's bloodstream, different vascular access options exist, including permanent access via surgical and percutaneous creation of fistulas and grafts (connection of an artery to a vein) or less preferred approaches such as the insertion of a central line catheter (an external tube) or arteriovenous grafts (AVG) (connecting an artery to a vein with a tube) that has poor higher infection rates, hospitalizations and increased mortality. In addition, vascular access centers provide placement services for peritoneal dialysis (PD) catheters (special tubes inserted in a patient's abdominal cavity to allow for home dialysis) and perform interventions to help mature and maintain fistulas.

Studies have shown that dedicated access centers like those operated by DVAC members provide higher quality care to Medicare beneficiaries at a lower than hospital outpatient departments. A 2017 study of vascular access care across sites found, by comparison to patients treated in hospital outpatient departments (HOPDs), patients treated in freestanding office-based vascular access centers were found to have lower all-cause mortality and fewer infections.[3] DVAC has recently updated its site-of-service analysis to include both office-based vascular access centers and ambulatory surgical centers (collectively freestanding outpatient centers, or FOCs) during the pandemic years period.

DVAC's updated study used propensity score matching to analyze data from the United States Renal Data System (USRDS) on Medicare beneficiaries for 2019 and 2020. A total of 82,498 patients who received ≥80% of their access-related care at a FOC were individually matched to 66,188 patients who received ≥80% of their access-related care at a HOPD. The study reviewed 930,803 patient encounters for vascular access repair and maintenance during the 2-year period.

Annual mortality was significantly lower in those treated at a FOC than in those treated at a HOPD (16.55 versus 18.11%; difference = -1.55%; $p<0.001$). Those treated at a FOC also experienced fewer infections (0.33 versus 0.89 per person-year; difference = -0.57; $p<0001$). Access type varied by the site of service as well with patients treated at a FOC having more AV Fistulas (71.0% versus 62.9% per person-year; difference = +7.9%; $p<0.001$) and 9.8% fewer Central Venous Catheters (CVCs) in the FOC (10.3%) compared with HOPD (20.2%) which was significant. Monthly costs for those treated at a FOC were $835.55 lower than those treated at a HOPD (7,081.75 versus 7,917.30, respectively; $p<0.001$) for annual savings in the FOC

[3] El-Gamil, Audrey et al., *What is the best setting for receiving dialysis vascular access repair and maintenance services?*, September 2, 2017

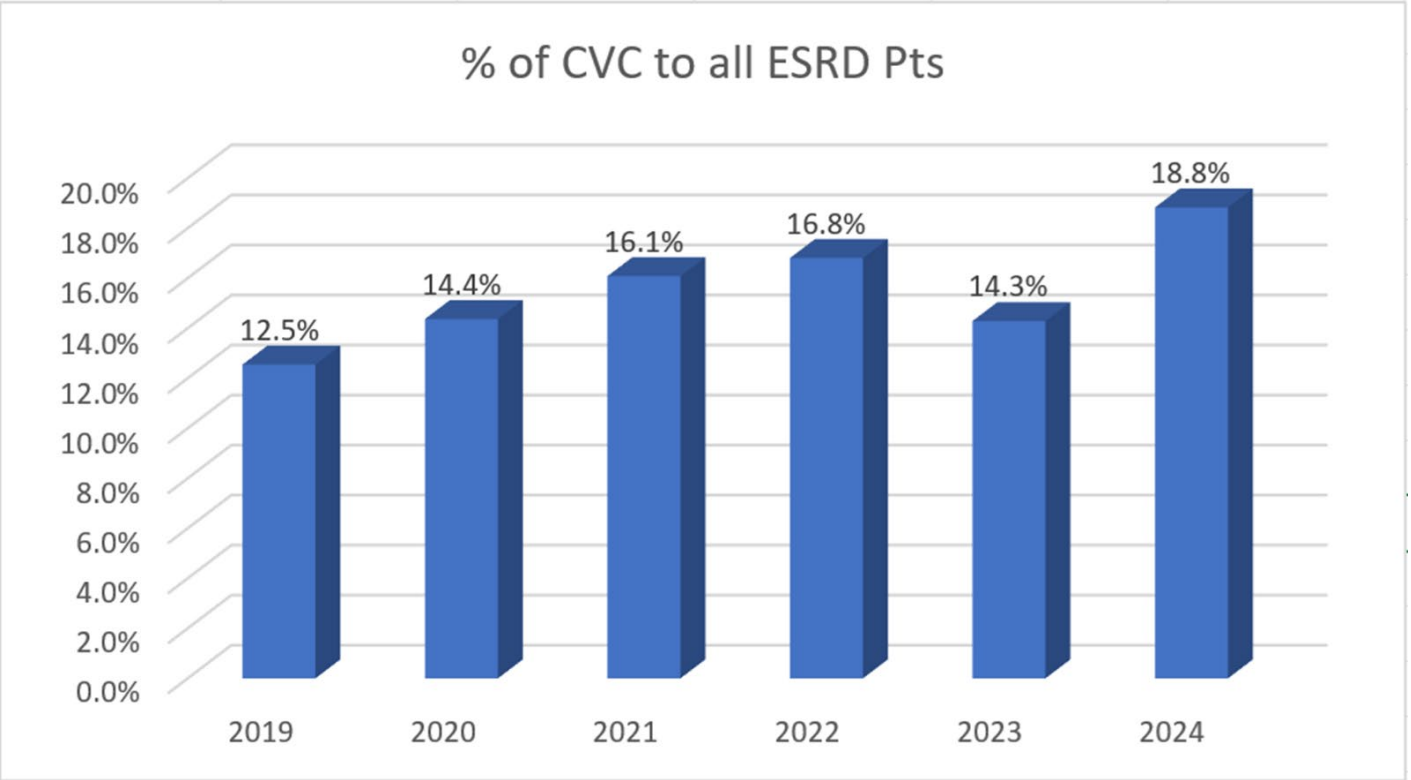
setting of $10,020 when compared with the HOPD setting. The outcomes were improved and the cost of non-hospital based vascular access care significantly less, which provides great value to the patients on dialysis in the U.S. in 2025.

In summary, patients receiving access-related care predominantly at a FOC had greater AVF use with a lower use of CVCs, fewer infections, and a lower mortality rate than those receiving care at a HOPD. These outcomes were achieved at substantially lower cost. The study has been submitted for publication and provides additional evidence of the value of non-hospital based vascular access for (1) patients on dialysis and (2) the Medicare program as a whole.

II. REIMBURSEMENT PRESSURES FACING NON-HOSPITAL DIALYSIS VASCULAR ACCESS ARE CONCURRENT WITH RISE IN CATHETER RATES

Notwithstanding the value and important of dialysis vascular access to ESRD patients and keeping Medicare costs low, Central Venous Catheter (CVC) rate rose 30% during the Biden Administration (from 14.4% in 2020 to 18.8% in 2024).[4] This rise in catheter rates is shown in Chart I below.

CHART I



These findings are consistent with the 2024 United States Renal Data System (USRDS) report which found the following:

[4] Vasc-Alert year end summaries of ESRD Patients. https://www.dialysisvascularaccess.org/reducing-catheter-rates

- The overall percentage initiating dialysis with a functioning permanent access decreased from a peak of 20.0% in 2017 to 15.3% in 2022.[5]
- There are substantial differences by race with higher percentages of White (16.3%) and Asian (19.3%) new patients initiating dialysis with a functioning permanent access compared with Black (15.0%), Native American (13.9%), and Hispanic (12.4%) individuals.[6]

The correlation between reimbursement pressures facing non-hospital dialysis vascular access and the rise in catheter rates also is explicitly noted in the 2024 USRDS report as follows:

- The landscape of vascular access in the U.S., although perhaps marginally improved in some respects in 2022 relative to 2021, is discouraging [and is] likely a combination of at least two factors that emerged since 2017.[7]
- The first is the COVID-19 pandemic, during which, at least initially, creation of a permanent vascular access was considered an elective procedure. The COVID-19 pandemic was undoubtedly a major factor in recent declines in fistula use because permanent access creation procedures were likely affected when hospitals and outpatient surgical centers reduced outpatient surgeries, particularly those that were deemed non-emergent.[8]
- A second factor that likely contributed to lower use of permanent vascular access is a reduction in reimbursement for vascular access procedures performed in outpatient vascular access centers resulting from a 2017 change in the Medicare Part B Physician Fee Schedule. Reimbursement, which was cut by nearly 40% for some procedures, led to closure of more than 20% of vascular access centers in 2018 according to a survey by the Dialysis Vascular Access Coalition (Dialysis Vascular Access Coalition, 2021; Litchfield, 2019). These closures may have limited capacity to perform vascular access procedures and potentially resulted in decreases to vascular access care.[9]

The USRDS concluded its 2024 chapter on Vascular Access by noting "The nephrology community needs to do a far better job on the vascular access front…There should be renewed effort to establish permanent access prior to starting HD where suitable and appropriate and to maintain that access throughout the course of dialysis."

III. UPDATES TO PRACTICE EXPENSE (PE) METHODOLOGY – SITE OF SERVICE PAYMENT DIFFERENTIAL

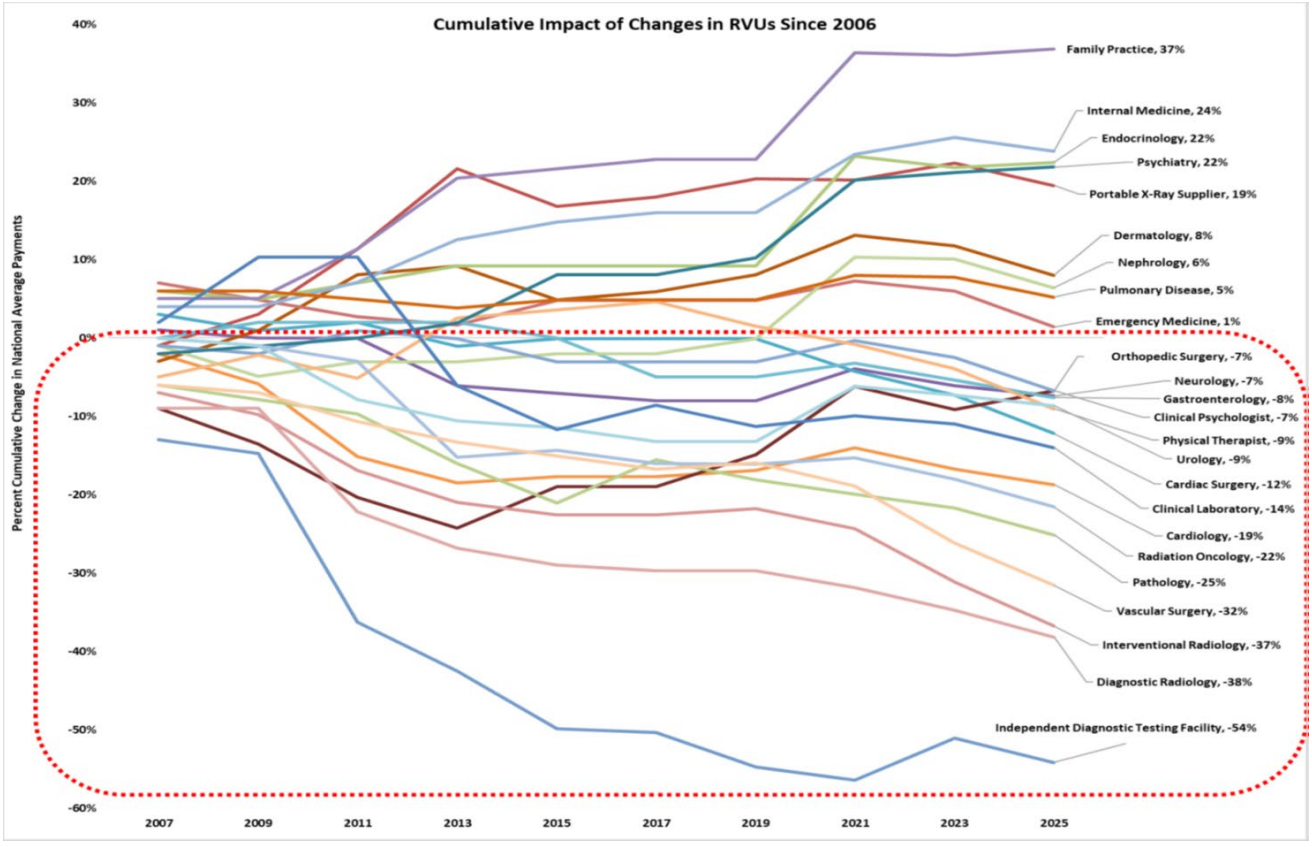
Many terms are synonymous with "office-based," including "private practice," "freestanding," "nonfacility," or "place of service 11" and such providers often are independent physicians, small businesses, and rural providers. In the 2026 PFS Proposed Rule, CMS notes strong concern relating to the collapse of private practice, stating:

[5] United States Renal Data System. 2024 USRDS Annual Data Report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2024
[6] Ibid
[7] Ibid
[8] Ibid
[9] Ibid

- [T]rends indicate a steady decline in the percentage of physicians working in private practice, with a corresponding rise in physician employment by hospitals; and growth in the percentage of physicians who practice exclusively, or almost exclusively, in the facility setting. When the PFS was established, the methodology for allocating indirect practice expense was based in part on an assumption that the physician maintained an office-based practice even when also practicing in a facility setting. In that context, the PE methodology has allocated the same amount of indirect costs per work RVU, without regard to setting of care.
- We share MedPAC's concerns regarding the potential for duplicative payment under the current PE methodology for allocating indirect costs for physicians practicing in the facility setting. Allocating the same amount of indirect PE per work RVU for services furnished in the facility setting as the nonfacility setting may no longer reflect contemporary physician practice trends.
- For these reasons, for each service valued in the facility setting under the PFS, we are proposing to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to nonfacility PE RVUs beginning in CY 2026.

For office-based interventional providers in particular, cuts since 2006 have been upwards of 20 – 40% or more (see Chart I).[10]

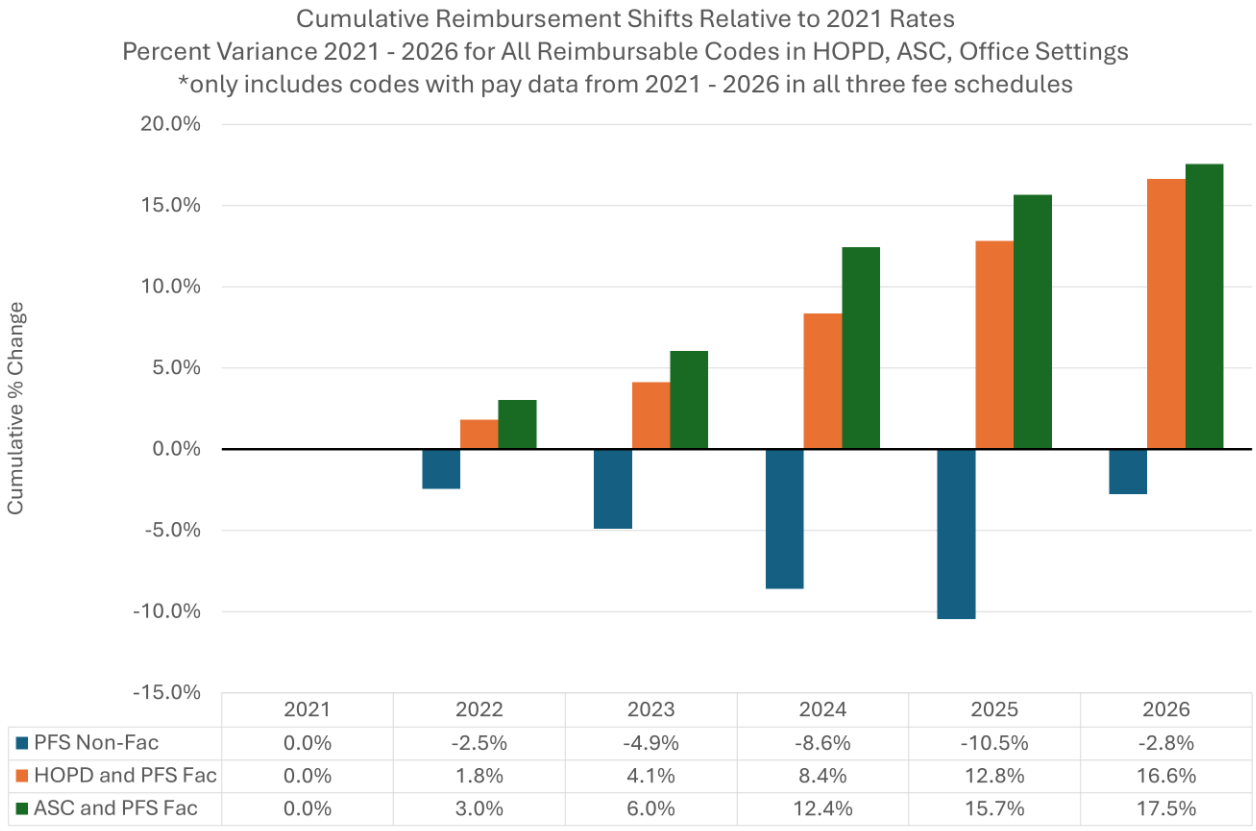
CHART I



[10] HMA analysis 2007-2025 Medicare Physician Fee Schedule Impact Tables.

Fortunately, due in part to the proposed update to the PE methodology, the 2026 PFS Proposed Rule marks the first meaningful improvement for office-based (i.e. non-facility) providers in years. Meanwhile, global HOPD and ASC rates also continue to rise, largely unaffected by the IPE policy.[11][12] To confirm our statements, we analyzed all codes common to HOPD, ASC, and non-facility settings over a 5-year period (see Chart II).[13] Since 2021, global facility rates have never declined year-over-year, while non-facility settings declined each year through 2025. Due to policies in the 2026 PFS Proposed Rule, 2026 finally brings an increase for all three of these settings. Still, over the five-year span, cumulative rate growth is 17.5% for ASCs, 16.6% for HOPDs, and -2.8% for office-based locations.

CHART II



	2021	2022	2023	2024	2025	2026
PFS Non-Fac	0.0%	-2.5%	-4.9%	-8.6%	-10.5%	-2.8%
HOPD and PFS Fac	0.0%	1.8%	4.1%	8.4%	12.8%	16.6%
ASC and PFS Fac	0.0%	3.0%	6.0%	12.4%	15.7%	17.5%

Cuts to office-based interventionalists have become so severe that, in 2025, there are 300 procedures across service lines that are paid at rates less than just the direct costs associated with

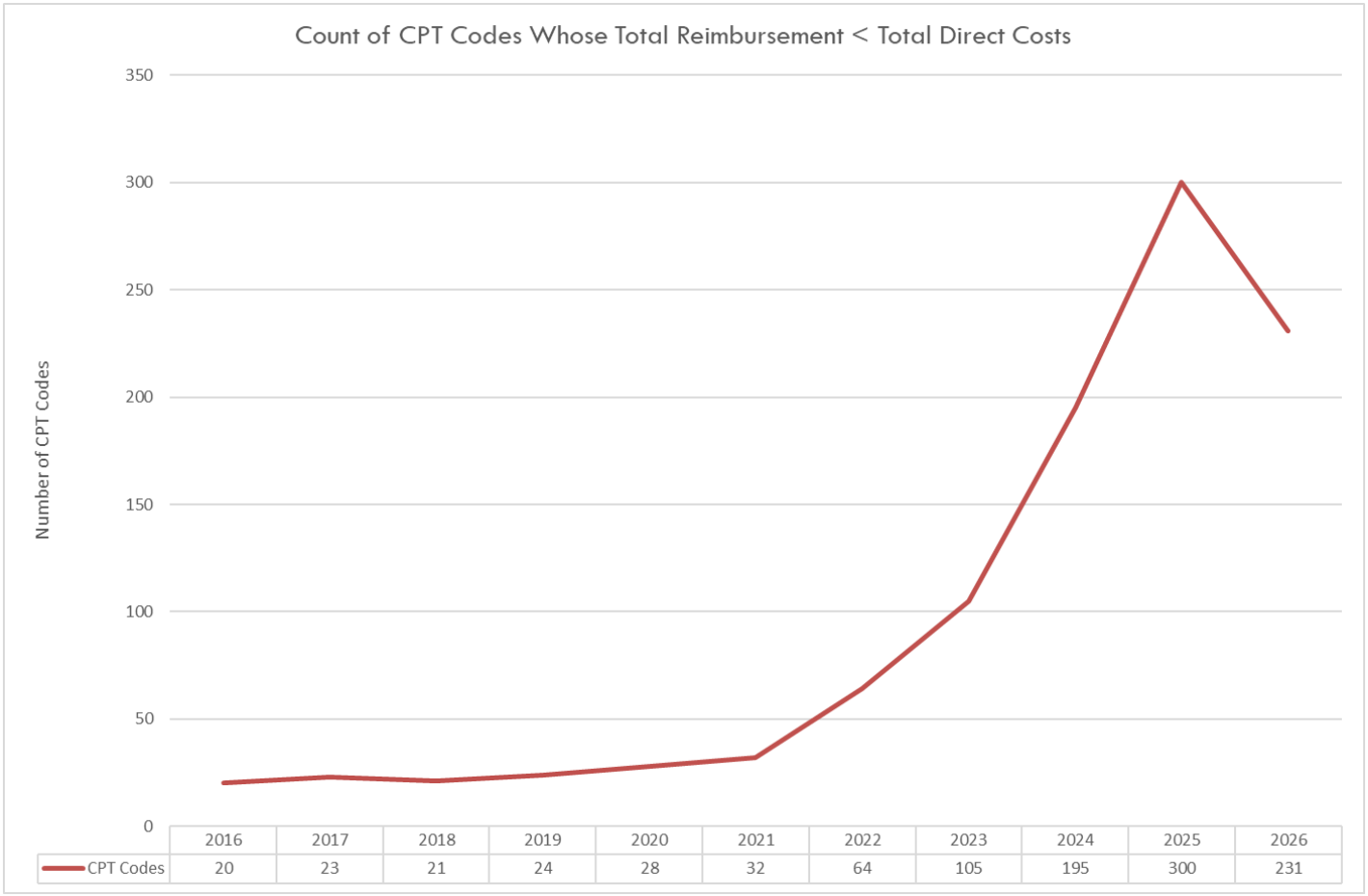
[11] In addition, physician compensation in hospitals tends to include base salary, work RVUs, quality incentives, etc. rather than PFS indirect practice expense. https://sullivancotter.com/wp-content/uploads/2020/11/Infographic-2020-Physician-Compensation-and-Productivity-Survey.pdf

[12] "Global" rates means PFS nonfacility (which includes professional and technical fees) as well as global hospital outpatient fees (hospital outpatient PPS tech + PFS facility) and global ASC fees (ASC PPS tech + PFS facility).

[13] Analysis is based on data from 2021 – 2025 final rules and 2026 proposed rule for the Hospital Outpatient PPS, ASC PPS and Physician Fee Schedules.

those procedures – as calculated by CMS itself (see Chart III).[14] The 2026 PFS Proposed Rule represents an important step in the right direct to correcting historical cuts to office-based interventional care, but additional actions must be taken to address this problem permanently.

CHART III



Physician Practice Information Survey

CMS rightly emphasizes in the rule that the AMA's Physician Practice Information Survey (PPIS) data is not a reliable benchmark for practice costs. In fact, PPIS has long blended practice expense and hourly rate (PE/HR) data between freestanding and hospital-based settings, which undermines

its relevance for office-based reimbursement.[15] The PPIS survey results would have triggered significant year-over-year cuts across office-based specialty interventional services (e.g. 37225 [limb salvage]: - 10.2%, 37243 [fibroid embolization]: -12.6%, 36475 [venous ulcer]: -12.6%,

[14] Analysis is based on data from 2016 – 2025 final rules and 2026 proposed rule for the Physician Fee Schedule.
[15] The Lewin Group analysis of PPIS data contained in the 2010 PFS Proposed Rule. Download available here: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/lewin_group_analysis_of_radiation_oncology.pdf

52441 [urology]: -15.2%, G6015 [radiation therapy]: -17.9, 36902 [dialysis vascular access]: -20.7%, 64555 [implant neuroelectrodes]: -26.5%).[16]

In contrast, maintaining the current MEI structures in collaboration with the IPE policy is a step toward a more equitable system. Such an approach supports community-based providers, improves access to essential preventive services (especially in rural and underserved regions), and helps reduce long-term costs for CMS. This is a meaningful and long-overdue correction and we commend CMS for taking action to preserve and strengthen community-based care delivery. For the vast majority of office-based specialties, the IPE policy will save their ability to practice independently.

REQUEST: The IPE policy advances patient-centered care, supports market-based solutions, and acknowledges the needs of many private practice, office-based, and independent physicians. DVAC supports the CMS proposal to update the IPE policy as a means of providing reimbursement stability that freestanding providers have desperately needed for the years.

IV. USE OF OPPS DATA TO SET PFS RATES

In the 2026 PFS Proposed Rule, CMS seeks comments on whether to use Hospital Outpatient Prospective Payment System (OPPS) mean unit cost data (MUC) and/or APC relative weights to price supplies and equipment for PFS services. For years, the AMA RUC has recommended "CMS separately identify and pay for high-cost disposable supplies priced more than $500."[17] Removing high-tech supply and equipment services from the PFS also could involve new "place of service" designations for such services and more appropriate inclusion in the larger ambulatory technical (i.e. OPPS/ASC) fee schedule. We believe the inclusion of certain high-tech supply and equipment services in the larger ambulatory technical (OPPS/ASC) fee schedule would be the best way for CMS to provide an "evidentiary basis to shape optimal PE data collection and methodological adjustments over time," given previous CMS statements that, "we continue to seek the best broad based, auditable, routinely updated source of information regarding PE costs."[18] Removing high-tech supply and equipment from the PFS also would free up resources within the PFS to achieve its primary raison d'être: reimbursement for physician work.

Reimbursing under the OPPS/ASC fee schedule for certain high-cost technical inputs used in office-based interventional care would stop further closures of independent procedural practices, given that the PFS effectively no longer covers such procedures. Importantly, such a policy also would (1) protect the PFS from further dilution from unsubsidized migration of high-cost equipment and supplies from the hospital and (2) provide additional resources for the overall PFS. Moreover, there is clear precedent for such action: in the 2010 PFS, the Centers for Medicare & Medicaid Services (CMS) finalized its proposal "to remove physician-administered

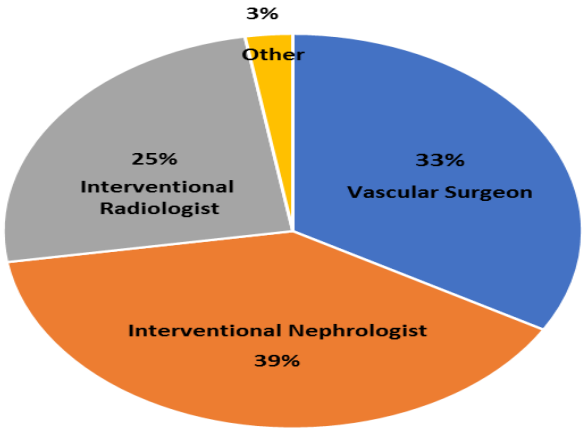
[16] Berkeley Research Group, Analysis of PPIS survey data impact on the Physician Fee Schedule, March 2025
[17] https://www.ama-assn.org/system/files/oct-2020-ruc-recommendations.pdf
[18] 83 FR 59455

drugs from the definition of physicians' services" due to the "significant and disproportionate impact that the inclusion of drugs has had on the SGR system."[19]

REQUEST: Because the PFS was not built for high-cost supplies and equipment, the DVAC supports the use of OPPS data to set rates for services utilizing high-cost equipment and supplies in the PFS, but recommends working with Congress to remove such services from the PFS altogether through mechanisms such as H.R. 10136 (the Promoting Fairness for Medicare Providers Act) and S. 1031 / H.R. 2120 (the ROCR Value Based Program Act).[20]

V. MIPS VALUE PATHWAYS

As discussed in previous comment letters, DVAC supported the CMS intention in the 2020 PFS Proposed Rule of MVPs as a way to create a cohesive and meaningful participation experience for clinicians by moving away from siloed activities and measures and towards an aligned set of measures that are more relevant to a clinician's scope of practice.[21] In that proposed rule, CMS specifically requested comment on whether MVPs should be organized around "areas of practice." DVAC continues to believe MVP reporting structures should be available for clinicians treating patients in centers of excellence such as dialysis vascular access centers of excellence where the majority of treatments relate to providing vascular access services to dialysis patients. As DVAC explained in its comment to the 2020 PFS Proposed Rule with the chart below, specialties treating at vascular access centers are split relatively evenly among interventional nephrologists, interventional radiologists, and vascular surgeons. It is likely that any specialty specific MVP option for one of these specialties would not contain the set of outcomes-based measures that would best meet the needs of dialysis patients served at vascular access centers of excellence.



In the 2026 PFS Proposed Rule, CMS states the agency anticipates being "ready to fully transition to MVPs by the CY 2029 performance period/2031 MIPS payment year."[22] DVAC is pleased to note that in the proposed rule that CMS has recognized dialysis related "clinical

[19] CY 2010 PFS Proposed and Final Rules. 74 FR 33650 and 74 FR 61965
[20] https://www.cureus.com/articles/282828-the-physician-fee-schedule-was-not-built-for-high-cost-supplies-and-equipment#!/
[21] 84 FR 40730
[22] 90 FR 32701

groupings" for each of the aforementioned specialties the coalition referenced in previous comments as follows. CMS is proposing the following dialysis-related clinical groupings for nephrology, interventional radiology, and vascular surgery as follows:

Optimal Care for Kidney Health MVP / Nephrology				
Clinical Grouping	*Quality*			*Cost*
	Measure	*Outcome*	*High Priority*	
Dialysis / Transplant	Q482: Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate (Collection Type: MIPS CQM)	Yes	Yes	COST_ESRD_1: End-Stage Renal Disease (*) TPCC_1: Total Per Capita Cost
	Q510: First Year Standardized Waitlist Ratio (FYSWR) (Collection Type: MIPS CQM)	Yes	Yes	
	Q511: Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) (Collection Type: MIPS CQM)	Yes	Yes	
	(^)(+) TBD: Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR) (Collection Type: MIPS CQM)	Yes	Yes	

Interventional Radiology MVP				
Clinical Grouping	***Quality***			***Cost***
	Measure	*Outcome*	*High Priority*	
Dialysis-Related	RCOIR12: Tunneled Hemodialysis Catheter Clinical Success Rate (Collection Type: QCDR)	Yes	Yes	MSPB_1: Medicare Spending Per Beneficiary (MSPB) Clinician COST_HAC_1: Hemodialysis Access Creation
	RCOIR13: Percutaneous Arteriovenous Fistula for Dialysis - Clinical Success Rate (Collection Type: QCDR)	Yes	Yes	
	RPAQIR14: Arteriovenous Graft Thrombectomy Clinical Success Rate (Collection Type: QCDR)	Yes	Yes	
	RPAQIR15: Arteriovenous Fistulae Thrombectomy Clinical Success Rate (Collection Type: QCDR)	Yes	Yes	

Vascular Surgery MVP				
Clinical Grouping	***Quality***			***Cost***
	Measure	*Outcome*	*High Priority*	
Dialysis-Related	RCOIR12: Tunneled Hemodialysis Catheter Clinical Success Rate (Collection Type: QCDR)	Yes	Yes	MSPB_1: Medicare Spending Per Beneficiary (MSPB) Clinician COST_HAC_1: Hemodialysis Access Creation
	RCOIR13: Percutaneous Arteriovenous Fistula for Dialysis - Clinical Success Rate (Collection Type: QCDR)	Yes	Yes	
	RPAQIR14: Arteriovenous Graft Thrombectomy Clinical Success Rate (Collection Type: QCDR)	Yes	Yes	
	RPAQIR15: Arteriovenous Fistulae Thrombectomy Clinical Success Rate (Collection Type: QCDR)	Yes	Yes	

REQUEST. DVAC appreciates the development of newly proposed "dialysis-related" vascular access clinical groupings for nephrology, interventional radiology, and vascular surgery. DVAC also continues to support CMS consideration of a "Dialysis Vascular Access" MVP category specifically relating to "dialysis vascular access," which would be reportable by any physician practicing in a dialysis vascular access center, including nephrologists, interventional radiologists, vascular surgeons, or primary care providers. DVAC would look forward to working with CMS on appropriate measures for such an area of practice.

VI. UNDERVALUATION OF CONVERSION FACTOR DUE TO G2211 ASSUMPTION

In a May 2025 letter to CMS, the AMA noted that, due to faulty assumptions relating to the adoption of the new G2211 code, that the PFS is underfunded by $1 billion. According to the AMA, in 2024, Medicare began paying for HCPCS code G2211, which was developed to be reported along with office visits when there is a longitudinal relationship between the physician and patient, and the physician serves as the continuing focal point for medical services that are part of ongoing care related to a patient's single, serious condition or a complex condition. Under the Medicare statute, CMS must annually adjust the Medicare CF to maintain budget neutrality, meaning that increases in payment for one service must be offset by corresponding decreases elsewhere, so that overall Medicare spending does not rise solely due to changes in relative value units. To determine the budget neutrality adjustment needed for G2211, the Biden Administration needed to develop an estimate of how frequently G2211 would be billed in 2024. The final estimate that CMS included in the CY 2024 MPFS final rule was that G2211 would be billed with 38 percent of all office/outpatient E/M visits reported in 2024. However, instead of being reported with 38 percent of all office visits, an AMA analysis of the first three quarters of 2024 Medicare claims data found that G2211 was reported with only 10.5 percent of office visits.

REQUEST: The DVAC supports AMA arguments on G2211 and urges CMS to correct the utilization estimate for G2211 based on actual claims data from 2024 by making a prospective budget neutrality adjustment to the 2026 CF in the 2026 PFS final rule.

VII. EFFICIENCY ADJUSTMENT

In the 2026 PFS Proposed Rule, CMS proposes applying a 2.5% decrease to the work RVUs and physician intra-service time of most services in the MPFS on the assumption that physicians have gained efficiency in providing them. This includes new services, surveyed for physician time and work within the past year. The decrease would be applied to 8,961 physician services. CMS arrives at a 2.5% efficiency adjustment by tallying the last five years' productivity adjustments in the MEI. However, physicians do not receive an MEI-based update even though other Medicare providers receive a productivity adjustment applied to their annual baseline updates (e.g., hospital market basket minus productivity). This proposal, combined with the AMA/Specialty Society RVS Update Committee's recommendations on individual CPT codes, results in the 0.55% budget neutrality adjustment to the conversion factor.

REQUEST: The DVAC does not support any efficiency adjustment policies within the Physician Fee Schedule without a concurrent automatic update to the conversion factor based on MEI.

CONCLUSION

DVAC's comments on the CY 2026 Physician Fee Schedule Proposed Rule seek to ensure ongoing access to vascular access services. We look forward to continuing to work with CMS to maintain and improve access to ESRD patient-focused vascular access services. If you have additional questions regarding these matters and the views of the DVAC, please contact Jason McKitrick at (202) 465-8711 or jmckitrick@libertypartnersgroup.com .


DIALYSIS VASCULAR
ACCESS COALITION


ASDIN
AMERICAN SOCIETY OF DIAGNOSTIC AND INTERVENTIONAL NEPHROLOGY


ASN
American Society of Nephrology


AKDHC
Arizona Kidney Disease & Hypertension Centers


AKA
AUSTIN KIDNEY
ASSOCIATES


azura
vascular care


BNMG
Balboa Nephrology Medical Group


DALLAS
NEPHROLOGY
ASSOCIATES
Comprehensive Kidney Care


Dialysis
Access Specialists


Lifeline
VASCULAR CARE


NANI
Nephrology Associates of
Northern Illinois and Indiana


Northwest
RENAL
Clinic, Inc.


RPA
Renal Physicians Association