September 14, 2026
The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1848-P CY2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz,

On behalf of the more than 37,000,000 Americans living with kidney diseases and the 22,000 nephrologists, scientists, and other kidney health care professionals who comprise the American Society of Nephrology (ASN), thank you for the opportunity to provide comments on the Calendar Year 2027 (CY) Payment Policies Under the Physician Fee Schedule proposed rule.

Chronic kidney disease (CKD) is a progressive condition characterized by the gradual loss of kidney function. It affects approximately 37 million Americans, or about 1 in 7 adults, and its prevalence is projected to rise. CKD poses an increasing public health crisis, resulting in considerable morbidity and growing health care expenditures. The U.S. Medicare program spends more than $150 billion each year managing kidney diseases, including $50 billion for kidney failure patients alone. ASN believes it is essential for the nation to reduce the burden of kidney diseases on individuals, their families, and the health care system overall. This priority aligns with the Trump Administration's chronic disease prevention efforts to Make America Healthy Again (MAHA).

In this letter, ASN offers comments and recommendations on several provisions of the proposed rule that have significant implications for nephrologists and the patients they serve. ASN also urges CMS to consider the broader sustainability of Medicare physician payment, particularly as physicians across specialties face increasing practice costs and financial pressures that threaten access to independent physician practices and the long-term stability of the physician workforce.

In this letter, ASN offers comments and recommendations on the following issues:

- Medicare Physician Fee Schedule Sustainability
- CY2027 PFS Rate Setting and Conversion Factor

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- E/M Resource Overlap Between Stand-Alone Visits and Global Periods
- E/M Visit Complexity Add-On HCPCS Code G2211
- Remote Monitoring
- CY2027 Modifications to the Quality Payment Program Reporting and Data Submission

Medicare Physician Fee Schedule Sustainability

ASN remains deeply concerned that Medicare physician payment has failed to keep pace with the rising costs of practicing medicine, placing increasing pressure on physician practices and threatening patient access to care. Between 2001 and 2025, Medicare physician reimbursement remained virtually flat, while operational costs surged by 59 percent. Adjusted for practice cost inflation, Medicare physician payment has declined by 33 percent over this same period[i].

This persistent gap has made it increasingly difficult for physicians, particularly those in independent practices, to sustain participation in Medicare and contributes to continued consolidation across the health care system[ii]. These financial pressures directly jeopardize care for patients with kidney diseases, who rely on complex, longitudinal management from nephrologists and multidisciplinary kidney care teams. Ensuring Medicare physician payment accurately reflects the real-world cost of delivering care is essential to sustaining independent practices, preserving the nephrology workforce, and safeguarding timely, high-quality care for individuals living with kidney disease.

ASN is also concerned that the Physician Fee Schedule's budget neutrality requirements create a structural limitation on efforts to address these longstanding payment challenges. Under the current framework, increases in payment for certain physician services generally must be offset by reductions elsewhere in the fee schedule, creating a competitive dynamic among medical specialties that share a common commitment to providing high-quality care. This can make it difficult to address services that may be persistently undervalued like kidney care delivery. Notably, this structural limitation does not apply in the same manner to Medicare payment systems for hospitals, ambulatory surgical centers, and other institutional providers.

ASN urges CMS and Congress to consider the broader sustainability of physician payment as they evaluate the Physician Fee Schedule. A sustainable payment system is essential to maintaining a robust physician workforce, preserving patient access to care, and supporting the delivery of complex, longitudinal services.

CY2027 PFS Rate Setting and Conversion Factor

The concerns raised regarding Medicare Physician Fee Schedule sustainability in the previous section of this letter are underscored by the proposed updates to the CY2027 conversion factors. CMS proposes conversion factors of $33.17 for qualifying APM participants and $32.84 for non-qualifying participants, representing decreases of 1.19 percent and 1.68 percent from CY2026.

While ASN acknowledges that these amounts reflect statutory updates and other required adjustments, the reductions are driven in part by the expiration of the temporary 2.5 percent increase Congress provided in CY2026. ASN expresses concern that returning to payment reductions immediately following a temporary payment increase underscores the continued instability of the Medicare physician payment system and the need for a permanent approach that provides predictable, sustainable updates over time.

E/M Resource Overlap Between Stand-Alone Visits and Global Periods

ASN strongly opposes CMS' proposal to reduce payment by 50 percent when a separately identifiable office/outpatient (O/O) evaluation and management (E/M) service reported with modifier -25 is furnished on the same day as a procedure with a 0-, 10-, or 90-day global period.

ASN has long emphasized the importance of appropriately valuing complex E/M codes services nephrologists provide to patients with kidney diseases, kidney failure, and kidney transplants. ASN raised similar concerns when CMS considered this policy in the CY 2019 Physician Fee Schedule, cautioning that reducing payment for E/M services would undervalue the "complicated, time-intensive cognitive care" required to manage people with kidney diseases[iii].

ASN remains concerned with CMS' assumption that furnishing a separately identifiable E/M service on the same day as a procedure necessarily creates efficiencies that warrant a reduction in payment. Nephrologists routinely manage medically complex people with kidney diseases who may require evaluation and management of acute kidney injury, electrolyte and acid-base abnormalities, volume overload, uncontrolled hypertension, changes in kidney function, or complications related to dialysis or kidney transplantation. When these issues require a significant, separately identifiable E/M service, the associated medical decision-making and physician work are distinct from the work of the procedure and should be appropriately reimbursed.

Reducing payment for these services based on a presumed overlap would undervalue medically necessary E/M care and could discourage physicians from addressing multiple clinically appropriate needs during a single encounter, leading potentially to prolonged hospital length of stay and delays in care that could impact clinical outcomes. This is particularly concerning for people with kidney diseases, who often face substantial treatment and appointment burdens and benefit from receiving necessary care in a coordinated and efficient manner. For example, a patient presenting with rhabdomyolysis and acute kidney injury may require significant evaluation and management as well as a kidney biopsy to further evaluate the cause or extent of kidney injury. If both services are clinically appropriate on the same day, reducing payment for the separately identifiable E/M service could create an incentive to delay the biopsy to a subsequent encounter, potentially delaying diagnosis and increasing the patient's care burden.

ASN also requests that CMS clarify how the proposed policy would apply when separately identifiable E/M services and procedures are furnished by physicians in different specialties who bill under the same TIN. This is particularly important for academic medical centers and other large multispecialty practices, where physicians may share a TIN despite providing distinct services with no meaningful overlap in physician work or practice resources—but who provide care that a patient may want or need to receive on the same day. For example, a kidney transplant recipient may see their nephrologist in the morning and then may want to see a dermatologist to remove immunosuppressant-caused cancerous skin growths in the afternoon. If the nephrologist and dermatologist are at the same academic medical center, and bill under the same TIN, the patient may be directed to schedule visits on two separate days—ultimately creating an unnecessary burden on the patient.

ASN urges CMS not to finalize the proposed 50 percent payment reduction and to continue providing full payment for significant, separately identifiable O/O E/M services appropriately reported with modifier -25.

E/M Visit Complexity Add-On HCPCS Code G2211

ASN supports CMS' proposal to transition HCPCS code G2211 to a modifier and establish a higher payment adjustment for eligible practitioners participating in the Medicare Shared Savings Program (MSSP) and Long-term Enhanced ACO Design (LEAD) model. G2211 has been particularly important and highly utilized in nephrology, where nephrologists provide ongoing, longitudinal care to medically complex patients with CKD, kidney failure, and kidney transplants[iv]. A percentage-based adjustment, rather than the current flat add-on payment, better preserves relativity across E/M visit levels and allows payment to scale with the level of the underlying E/M service.

ASN also appreciates CMS' recognition of the additional resources required of clinicians participating in value-based care arrangements. Nephrology has been at the forefront of Medicare's transition toward value-based specialty care, beginning with the ESRD Seamless Care Organizations (ESCOs) under the Comprehensive ESRD Care Model and continuing through the Kidney Care Choices (KCC) Model. In these models, nephrologists have assumed responsibility not only for providing longitudinal care to medically complex patients, but also for coordinating care and improving quality and outcomes while operating under accountability for Medicare expenditures.

ASN encourages CMS to extend eligibility for the proposed MOD2 adjustment to eligible nephrologists participating in the Comprehensive Kidney Care Contracting (CKCC) options of the KCC Model. ASN further encourages CMS and the Centers for Medicare and Medicaid Innovation (CMMI) to incorporate similar recognition into future kidney-focused value-based care models, ensuring that payment appropriately reflects the additional responsibilities and resources required of nephrologists participating in accountable care arrangements.

Remote Monitoring

ASN supports CMS' continued efforts to refine Medicare payment for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services while ensuring that these services are appropriately integrated into a patient's ongoing care. Remote monitoring can be particularly valuable for people with kidney diseases, who often require longitudinal monitoring and management of blood pressure, weight, volume status, and other clinical indicators between in-person encounters.

ASN supports CMS' efforts to ensure that remote monitoring services are furnished within an established clinical relationship and appropriately connected to the practitioner responsible for the patient's care. However, ASN encourages CMS to ensure that new requirements do not unnecessarily limit access to clinically appropriate remote monitoring services or create additional administrative burden for nephrology practices. As remote monitoring technologies and their use in clinical practice continue to evolve, Medicare payment policy should preserve sufficient flexibility for nephrologists and other members of the kidney care team to integrate these services into care based on the clinical needs of individual patients. Remote monitoring programs to manage chronic conditions like hypertension and cardiac kidney metabolic disease need to include longitudinal provider involvement to avoid fragmentation of care.

ASN also appreciates CMS' continued consideration of how the coding and payment structure for remote monitoring should evolve as these technologies mature. ASN encourages CMS to ensure that payment appropriately reflects the resources required to furnish these services and supports the continued adoption of remote monitoring technologies that facilitate timely, coordinated, and patient-centered kidney care.

CY2027 Modifications to the Quality Payment Program Reporting and Data Submission

ASN strongly supports the appropriate use of SGLT2 inhibitors for people with CKD and supports the inclusion of an SGLT2 inhibitor measure in MIPS. However, ASN recommends that CMS modify the proposed measure specifications to better align with the current evidence base and identify patients for whom treatment is clinically appropriate. Specifically, for patients with stage 2 or 3 CKD, the measure should reflect an albuminuria threshold of at least 200 mg/g urine albumin-to-creatinine ratio (uACR).

With these modifications, ASN strongly supports adding the SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus measure to the Nephrology, Cardiology, Family Medicine, Geriatrics, and Internal Medicine Specialty Sets. ASN has long advocated for quality measures that promote evidence-based treatment to slow the progression of CKD and strongly agrees with CMS that this measure addresses an important gap in the MIPS quality measure inventory. SGLT2 inhibitors are recommended in current clinical practice guidelines for appropriate patients with CKD and have demonstrated significant kidney and cardiovascular benefits, including slowing disease progression and reducing the risk of kidney failure. Incorporating their appropriate use into MIPS will better align Medicare

quality measurement with contemporary standards of CKD care and promote improved outcomes for people with kidney diseases.

ASN also seeks clarification regarding whether CMS intends to incorporate this measure into the Kidney Health MIPS Value Pathway (MVP). Given the measure's direct relevance to CKD management and disease progression, ASN strongly encourages CMS to include this measure in the Kidney Health MVP and ensure that kidney-focused quality measurement continues to evolve alongside advances in the standard of care.

Conclusion

ASN appreciates the opportunity to provide comments on the CY 2027 Physician Fee Schedule proposed rule and commends CMS for its continued efforts to strengthen Medicare payment and advance high-quality care for beneficiaries. As CMS finalizes these policies, ASN urges the agency to ensure that Medicare payment appropriately recognizes the complexity of care provided to people with kidney diseases, supports the sustainability of nephrology practice, and promotes access to evidence-based, patient-centered care.

ASN stands ready to provide additional information or engage its expert members as CMS considers these recommendations. Please contact ASN Policy and Government Affairs Associate Lauren Ahearn at lahearn@asn-online.org to discuss this letter or ASN's recommendations further.

Sincerely,

Samir M. Parikh, MD, FASN
President

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[i] 2025 MAC Medicare Physician Payment Issue Brief | AMA

[ii] June 2025 Report to the Congress: Medicare and the Health Care Delivery System – MedPAC

[iii] https://www.asn-online.org/policy/webdocs/18.9.10FINAL_Submitted_PFS_Comments.pdf

[iv] https://jamanetwork.com/journals/jama/fullarticle/2845315