American Society of Nephrology

September 12, 2025
The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20001

Re: CMS-1832-P Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule

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 (CY) 2026 Medicare Physician Fee Schedule (MPFS) Proposed Rule. ASN also wishes to reiterate our appreciation for your Administration's commitment to kidney health, exemplified by President Trump's executive order on July 10, 2019, that launched the Advancing American Kidney Health initiative (AAKH). ASN hopes to continue to engage with the White House, President Trump, and CMS on this important issue.

The Advancing American Kidney Health initiative seeks to:

- Prevent kidney failure (a chronic condition) through better diagnosis, treatment, and notably, preventative care.
- Increase affordable alternative treatment options, educate patients on treatment alternatives, and encourage the development of artificial kidneys.
- Increase access to kidney transplants by modernizing the transplant system and updating counterproductive regulations.

While we, as the nation's kidney doctors, have made great progress in increasing home dialysis, supporting innovation in new therapies for kidney diseases, and leading advances in kidney transplant, there is still much work left to be done. Chronic kidney disease (CKD) is a progressive, chronic condition characterized by the gradual loss of kidney function[i]. It affects approximately 37 million Americans, or about 1 in 7 adults, and its prevalence is projected to rise[ii]. CKD results in considerable morbidity and substantial health care expenditures. The U.S. Medicare program spends more than $150 billion each year managing people with kidney diseases, including $50 billion for

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kidney failure patients alone[iii]. ASN believes that it is essential as a nation to reduce the burden of kidney diseases on both individuals and their families as well as the health care system overall, which aligns with the administration's focus on mitigating chronic disease and improving wellness.

CMS has proposed several provisions in this proposed rule that are relevant for our shared mission of combatting kidney diseases:

- Creating two conversion factors based on qualified participant (QP) status, both with increases from last year in the Quality Payment Program (QPP) and two for Medicare payments to all physicians who are not qualifying participants, including those who are eligible for Merit-based Incentive Payment System (MIPS);
- Proposing changes to work and practice expense RVUs;
- Codifying some aspects of Medicare telehealth;
- Modifying the Merit-based Incentive Payment System (MIPS) while maintaining the current performance threshold;
- Making numerous changes to the Medicare Shared Savings Program (MSSP).

CY 2026 PFS Provisions

Quality Payment Program Conversion Factors

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Quality Payment Program (QPP), which was created by MACRA, replaced the outdated Sustainable Growth Rate (SGR) formula with two tracks for QPP participation: the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

The proposed update to the qualifying APM conversion factor for CY 2026 is +0.75 percent while the update to the nonqualifying APM conversion factor for CY 2026 is +0.25 percent. Although ASN welcomes an increase in physician payment, the 0.25% update (and even the 0.75% update) is far below the rate of inflation as measured by the Medicare Economic Index (MEI), which CMS projects will be 2.7 percent from 2024 to 2026, reflecting the rising costs of medical practice. Although physicians will see a 2.5% payment increase for 2026 passed in the July 2025 reconciliation package, H.R.1, this is a temporary one-year increase.

ASN supports permanent baseline updates to the conversion factors that realistically account for the growth in physician practice costs, as measured by MEI.

In their June 2025 Report to Congress, the Medicare Payment Advisory Commission[iv] (MedPAC) also expressed concerns about the growing gap between physicians' practice costs and Medicare payment that could result in reducing the number of Medicare beneficiaries physicians treat or stop participating in Medicare entirely. ASN shares this concern, particularly with regards to people with kidney diseases, and we

advocate for the current payment system to keep pace with the rising costs of running a medical practice to ensure that people with kidney diseases have access to the care they need.

Practice Expense

ASN is also concerned about services in nephrology that are explicitly tied to facility-based f payment and note that, in many instances, there is no office-based practice equivalent that can offset facility-based care. This is particularly true for specific areas of nephrology care:

a. **Pediatric Kidney Care** presents an opportunity to reduce the burden of chronic illness and associated lifelong costs, as pediatric nephrologists are trained to identify and treat young people at risk for kidney disease progression. Children residing in states with a higher density of pediatric nephrologists have better access to transplantation[v], a key goal of President Trump's Advancing American Kidney Health initiative. There is currently a pediatric nephrology workforce crisis that is likely to worsen in the next 20 years, resulting in limitations in access to pediatric nephrologists and in geographical disparities whereby only those children residing near major metropolitan areas will have access to pediatric nephrology care[vi]. ASN has concerns about the impact of the proposed changes on pediatric nephrology practices, which for many reasons are predominantly based in academic tertiary care hospital facilities[vii]. ASN would be pleased to discuss this critical issue with you in further detail, recognizing that pediatrics is an uncommon topic for Medicare (but one that is relevant here due to the fact that children with kidney failure often qualify for Medicare on the basis of ESRD), and, in the interim, encourages CMS to reconsider the likely significant financial implications of this proposal on the care of children with kidney disease.
b. **Transplant Nephrology** will be substantially impacted by elements of this proposed rule, especially the Practice Expense (PE) methodology overhaul (halving indirect PE in facility settings) and the efficiency adjustment. These will materially reduce reimbursement for transplant nephrologists who do not have offsetting office-based volume. Transplant nephrologists are typically based at transplant centers, allowing close collaboration with other members of the multidisciplinary team and access to sophisticated diagnostics and therapies. The proposed nearly 10% reduction in reimbursement comes at a time that CMS has also implemented the Increasing Organ Transplant Access (IOTA) model, which encourages the growth of transplant programs including the use of less-than-ideal organs that will require increase coordination of care and is associated with more complex care. Given the ability of transplantation to dramatically improve patient survival and reduce costs, lowering reimbursement at this time is likely to adversely impact transplantation
c. **Tertiary Care Nephrology**, with its focus on the most complicated cases in adult medicine, including primary glomerulonephritis, complicated

autoimmune diseases, and multiorgan failure, will face similar adverse impacts. Nephrologists in tertiary and quaternary centers typically are caring for individuals with exceptionally complicated medical conditions requiring cross-disciplinary collaboration and frequently complex medication regimens and treatment plans; these patients are referred by community-based nephrologists due to their complexity. This complexity and interdisciplinary need often go uncaptured in current E/M billing.

Instead ASN proposes alternative approaches, supporting both the IOTA model and the care of vulnerable children with kidney disease:

1) Maintain the current PE methodology for services that do not have a significant office-based offset such as transplant and pediatric nephrology.
2) Create a transplant-specific add-on G code to account for the complexity of care in the post-transplant setting.
3) Consider the use of limited adjustment of the PE methodology for facility-based specialty care

Efficiency Adjustment

CMS is proposing a permanent adjustment to the work Relative Value Units (RVUs) and the corresponding intra-service portion of physician time. The justification is that physicians have become more efficient over time, and therefore the time and effort (and thus the associated RVUs), should be reduced. This would periodically apply to all codes, with the exception of time-based codes. An efficiency adjustment of -2.5 percent would apply for CY 2026.

ASN is concerned that the efficiency adjustment of a 'one-size fits-all' reduction does not reflect the realities of nephrology practice. The rationale for a 2.5% reduction is unclear, particularly given that nephrologists are increasingly caring for older and more medically complex patients, reflected in that nephrologists frequently bill based on complexity, not on time. Unlike manufacturing, where efficiencies may be gained over time, advances in nephrology have increased the complexity of care, especially for patients with CKD where new therapies create opportunities to slow progression (ultimately with huge dividends for patients and for society). Continued investment in this care has the potential to improve patient outcomes and ultimately reduce costs by lowering the number of patients who develop end-stage renal disease.

ASN urges CMS to reconsider this proposal and pursue a different approach, advocating for a more collaborative process where CMS could work directly with nephrologists to address any concerns about efficiency on a code-by-code basis. Given the administration's focus on chronic illness and the pervasiveness of CKD, there is an imperative to not decrease funding for timely nephrology care that can stem the progression of CKD to renal failure.

Nephrology-Specific Issues

As background, the 2019 Executive Order aimed to increase the use of home dialysis, recognizing that home dialysis was an underutilized modality of care with increased patient-centeredness and potential clinical and cost benefits. ASN recognizes that individuals with kidney failure must have access to the treatment option that best aligns with their clinical needs and personal circumstances. ASN thanks CMS for its support of home dialysis modalities and urges continued efforts to promote these options so every patient can choose the modality that best works for them.

Critically, home dialysis with either home hemodialysis (HHD) or peritoneal dialysis (PD) offers significant lifestyle benefits, including faster recovery after treatment and the ability to schedule dialysis in such a way to facilitate ongoing employment and participation in other critical activities like attending school, pursuing hobbies, and providing childcare and other caregiving.[viii]

While many decisions related to ESRD are done via the yearly End-Stage Renal Disease Prospective Payment System & Quality Incentive Program (ESRD PPS QIP) rule, there are many elements of the physician fee schedule that are key to the practice of nephrology and can influence patient ability to access home dialysis therapies. ASN offers the following comments to this year's proposed rule:

1) Streamlining the Medicare Telehealth Services List

ASN has consistently supported expanded access to telehealth and remote patient monitoring, which are crucial for patients with end-stage kidney disease (ESRD). In fact, ASN was instrumental in advocating for the change in law that allowed the home to be included as an originating site for the monthly capitated payment visit for dialysis patients. ASN and others have also worked extensively with CMS to ensure that patients and providers had access to telehealth during the public health emergency and after. ASN appreciates CMS' continued commitment to expanded telehealth so that patients can continue to have access to essential health services if they are unable to attend a clinic visit in person.

In this year's proposed rule, CMS proposes changes to streamline how new codes would be added to the Medicare Telehealth Services List. ASN is broadly supportive of the proposed changes to the 5-step process and appreciates CMS' focus on clinical decision-making and professional judgment in determining when and how telehealth can be appropriate for patients. ASN agrees that removing the "provisional" status from the Medicare Telehealth Services List will help to simplify the process and is pleased to see a number of ESRD related codes moving from provisional to permanent status under this change.

These codes include:

90951 - 53 ESRD serv 1 visit p mo <2 yrs

90954 - 56 ESRD serv 1 visit p mo 2-11 yrs

90957 - 59 ESRD serv 1 visit p mo 12-19 yrs

90960 - 62 ESRD serv 1 visit p mo 20+ yrs

2) Kidney Disease Education

The ASN urges CMS to make changes to increase access to the Kidney Disease Education (KDE) benefit. ASN appreciates CMS's attention to this issue, particularly through finalizing expansions of KDE within the ESRD Treatment Choices (ETC) Model. ASN believes that there are additional steps, described below, that CMS can take to make KDE more accessible to patients:

i. Waiving the KDE coinsurance requirement

Currently, Medicare beneficiaries are responsible for the 20% copay associated with KDE as a Part B benefit. For some beneficiaries, the 20% coinsurance is prohibitive to accessing these important educational services. ASN recommends that CMS waive the coinsurance requirement that would otherwise be applicable under section 1833(a)(1) of the Social Security Act concerning KDE services for beneficiaries.

ii. Adjusting KDE codes for inflation

ASN urges CMS to consider increasing the payment for HCPCS codes G0420 and G0421, which are used for individual face-to-face education services and group face-to-face education services related to CKD. These codes are not aligned with current inflation levels and should be revised accordingly. Further, ASN believes that the current payment level is not reflective of CMS' commitment to home dialysis. Studies have shown that when patients receive education, they are more likely to choose a home modality. A code update could therefore incentivize more KDE, which aligns with CMS' ultimate goal of increasing home dialysis uptake. [ix]

3) Adjusting other Home Dialysis-Related Codes for Inflation

Dialysis Training: The HCPCS code 90989 for dialysis training has not been updated since the mid-1990s. We urge CMS to adjust this code for inflation. We believe that an increase to this code's payment will result in greater utilization of home dialysis.

4) The Importance of Supporting Vascular Access Codes

Vascular access is required for both in-center and home hemodialysis patients; options include surgically or percutaneously creating fistulas (connecting an artery to a vein) or less preferred methods like inserting a central line catheter or arteriovenous grafts

(AVGs). Simply stated, safe and effective hemodialysis depends on timely vascular access. ASN urges CMS to prioritize sustainable reimbursement for vascular access codes.

5) Incentives for PD Catheter Placement

Currently, PD catheter procedures are generally reimbursed at a much lower rate than fistula creation. We believe that CMS should consider equalizing the reimbursement between PD catheter placement procedures and other vascular access placement procedures. This difference in reimbursement helps to explain a motivation to perform more vascular procedures as opposed to PD catheter insertions. It also raises the question of whether, should the reimbursement be equalized, more PD catheter insertions would be performed.

New MIPS Quality Measures Proposed for the CY2026 Performance Period/2028 MIPS Payment Year and Future Years

CMS has proposed inclusion of the Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR) measure in MIPS for the CY2026 Performance Period. Notably, this measure would be part of the Optimal Care for Kidney Health MVP, which was originally developed by ASN.

In addition, ASN offers comments on two measures finalized in the PY2025 Medicare Physician Fee Schedule that ASN has identified as problematic. These measures, finalized for inclusion in MIPS for the CY2025 Performance Period and the 2027 MIPS Payment Year, are:

- Q510: First Year Standardized Kidney Transplant Waitlist Ratio
- Q511: Percentage of Prevalent Patients Waitlisted for Kidney Transplant (PPPW) and Percentage of Prevalent Patients Waitlisted for Kidney Transplant in Active Status (aPPPW)

Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR)

ASN recognizes the importance of improving transplantation rates for patients with kidney failure but does not support the Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR) measure. While referral to a transplant center and initiation or even completion of the waitlist evaluation process could serve as appropriate metrics for these levels of analysis in CMS' quality programs, the proposed clinician/group level PSWR measure is not. Decisions about placing a patient on the transplant waitlist are made primarily by each individual transplant center and lie beyond the control of the physicians and physician groups targeted in this measure.

Notably, the PSWR measure was not recommended for use during the 2024–2025 Pre-Rulemaking Measure Review (PRMR) conducted by the Consensus-Based Entity (CBE), Battelle's Partnership for Quality Measurement[x]. The PRMR Clinician Advisory

Recommendation Group raised several concerns that align with ASN's position, including:

- **Historically not recommended for use:** the measure has been repeatedly deemed not appropriate for use across multiple review cycles, including the failure to gain CBE endorsement during the Fall 2022 E&M Cycle.
- **Insufficient exclusions:** particularly the failure to account for patients who choose not to pursue waitlisting.
- **Misattribution of accountability:** the measure unfairly assigns responsibility for waitlisting decisions to nephrologists, despite the central role of patients and transplant centers.

ASN strongly objects to attributing successful or unsuccessful placement on a transplant waitlist to individual physicians or group practices. As stated above, the waitlisting process involves multiple parties that are unrelated to the nephrologist or care team, which can lead to potential obstacles and delays in care. For example, changes in a patient's private insurance can repeatedly disrupt eligibility evaluations. Penalizing physicians or group practices for factors like these is inconsistent with the principle that attribution models should fairly and accurately assign accountability.

Furthermore, transplant eligibility criteria vary widely across geographic regions and transplant centers. For example, one center may require documentation of the absence of chronic osteomyelitis or heart failure, while another may apply different or additional requirements. This variability contributes to significant disparities in listing rates across centers and undermines the validity of the measure.

ASN believes that the PSWR and other waitlisting-related measures, in their current proposed forms, fail to align incentives across the continuum of care. ASN objects to CMS' decision to proceed with the inclusion of the PSWR measure in its quality programs, despite its repeated failure to receive CBE endorsement in addition to repeated failure to be recommended for inclusion in CMS programs**.** When measures are reconsidered for inclusion in a subsequent rulemaking cycle, developers are expected to demonstrate how they have modified the measure in response to previous concerns and to outline a plan for achieving endorsement**.** ASN observes that the PSWR developer has not provided such evidence, further underscoring the measure's lack of readiness for adoption. ASN urges CMS to adopt measures that more accurately reflect the role of nephrologists in the transplantation process and that promote high-quality care for patients with kidney failure.

<u>Q510: First Year Standardized Kidney Transplant Waitlist Ratio and Q511: Percentage of Prevalent Patients Waitlisted for Kidney Transplant (PPPW) and Percentage of Prevalent Patients Waitlisted for Kidney Transplant in Active Status (aPPPW)</u>

In accordance with Executive Order (EO) 14192, "Unleashing Prosperity Through Deregulation," which seeks to streamline Medicare regulations, reduce administrative

burdens on providers, suppliers, beneficiaries, and other stakeholders, and directs CMS to solicit public feedback on potential changes[xi], ASN would like to highlight two previously finalized waitlisting measures the society finds problematic. These measures were finalized in the CY2025 Physician Fee Schedule Final Rule for inclusion in MIPS for the CY2025 Performance Period and 2027 Payment Year[xii]:

- Q510: First Year Standardized Kidney Transplant Waitlist Ratio (FYSWR)
- Q511: Percentage of Prevalent Patients Waitlisted for Kidney Transplant (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW)

ASN supports the overall goal of increasing access to kidney transplantation for patients with kidney failure, but it does not believe that the Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR), First Year Standardized Waitlist Ratio (FYSWR), Percentage of Prevalent Patients Waitlisted (PPPW), or Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) are appropriate MIPS measures. While these measures track placement on the transplant waitlist or receipt of a living donor transplant, they largely assess outcomes that are beyond the control of nephrologists or physician groups. As noted above regarding the PSWR measure, decisions regarding waitlisting and transplant eligibility are primarily made by individual transplant centers, and factors such as patient health at dialysis initiation, insurance status, and center-specific criteria can significantly affect whether a patient is waitlisted or transplanted. Because nephrologists have little ability to influence these outcomes, attributing performance to them does not accurately reflect their role in the transplantation process.

Additionally, ASN is concerned that these measures lack sufficient exclusions and fail to account for patients who opt out of waitlisting, and they do not align incentives across the continuum of care. Active or inactive status on the waitlist is determined entirely by the transplant center, not the referring nephrologist, and substantial variability in listing practices among centers further undermines the reliability and validity of these measures. In addition, PRMR did not support FYSWR and only conditionally supported PPPW, echoing ASN's concerns. ASN urges CMS to implement measures that focus on aspects of care nephrologists can influence, such as timely referral for transplant evaluation, while ensuring accountability aligns with the entities responsible for waitlisting and transplant decisions.

Conclusion

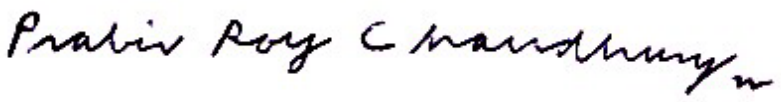
ASN appreciates the opportunity to comment on the CY 2026 Medicare Physician Fee Schedule proposed rule. As detailed above, ASN urges CMS to reconsider proposals that would reduce access to vital nephrology services, particularly those affecting pediatric nephrology and transplant nephrology, as well as proposed MIPS transplant measures that do not accurately reflect nephrologists' role in the transplantation process. At the same time, ASN encourages CMS to pursue policies that support innovation in kidney care, sustain access to home dialysis, modernize vascular access reimbursement, and strengthen patient education benefits.

In response to CMS's request for information on addressing chronic conditions, ASN emphasizes that kidney diseases are increasingly prevalent in the U.S. and that early identification and management are essential to delaying progression to kidney failure and preventing related complication. Recent innovations, including the development of SGLT2 inhibitors, demonstrate the promise of slowing kidney disease progression and improving outcomes for patients. ASN urges CMS to adopt payment policies that both incentivize continued innovation in kidney care and support comprehensive, patient-centered management of kidney diseases, recognizing that these approaches are critical to lowering long-term Medicare expenditures and improving patient well-being.

ASN looks forward to continuing to work with CMS, the White House, and Congress to advance policies that improve the lives of the more than 37 million Americans living with kidney diseases.

To discuss this letter further, please contact David White, ASN Senior Regulatory and Quality Officer, at dwhite@asnonline.org.

Sincerely,



Prabir Roy-Chaudhury, MD, PhD, FASN
President

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