American Society of Pediatric Nephrology
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September 12, 2025

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

Submitted electronically via Regulations.gov

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

Dear Administrator Oz,

The American Society of Pediatric Nephrology (ASPN) is pleased to provide these comments on the CY 2026 Medicare Physician Fee Schedule (MPFS) proposed rule. Founded in 1969, ASPN is a professional society composed of pediatric nephrologists whose goal is to promote optimal care for children with kidney disease and to disseminate advances in the clinical practice and basic science of pediatric nephrology. ASPN currently has over 700 members, making it the primary representative of the Pediatric Nephrology community in North America.

We write today representing the approximately 10,000 children living with end-stage kidney disease (ESKD) where the kidneys can no longer function on their own, relying on either dialysis or a kidney transplant to survive. Children with ESKD are the only children automatically eligible for Medicare based on their condition under statute, and approximately one-third are covered by the program with another third covered by Medicaid and the remaining third covered by private insurance. The children treated by our members are likely to be enrolled in the Medicare program multiple times throughout their lives prior to turning 65 as they go on and off dialysis and potentially receive multiple kidney transplants. With this perspective, we are providing comments on the following policy proposals:

- Proposed Efficiency Adjustment
- Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential
- Request to Add Dialysis Services to the Medicare Telehealth Services List
- Request for Information on Prevention and Management of Chronic Disease

Proposed Efficiency Adjustment

The Centers for Medicare & Medicaid Services (CMS) believes that certain physician services – procedures, diagnostic tests, and radiology services – are overvalued because their values do not reflect the efficiency gains in physician work relative value units (RVUs) and intraservice time. The agency proposes to apply an efficiency adjustment to all services, except those that are time-based; E/M services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period (designated by global period indicator MMM) would be excluded from this policy. The initial efficiency adjustment is proposed to be -2.5%, the cumulative total of the Medicare Economic Index (MEI) productivity adjustment for the last five years. After this initial decrease, CMS proposes to apply this productivity-based reduction every three years using the latest data.

ASPN has significant concerns with this proposal and urges the agency not to finalize it. Instead, the agency should work with specialty societies to develop an alternative policy that will not penalize non-proceduralists, like nephrologists, who perform some office-based procedures. Our members perform some procedures on children, including kidney biopsies, blood draws, and immunization administration, which are inherently different from many of the procedures with which CMS is concerned. These services do not typically benefit from technological advancements.

Additionally, physicians may initially become more efficient after entering practice but ultimately their efficiency plateaus. As proposed, CMS' policy assumes that physicians continue to become ever more efficient in the delivery of procedures over time with the value of these procedures scheduled to decrease sequentially every three years. We strongly disagree that efficiency gains continually accrue for the procedures our members deliver; once a level of expertise has been obtained, a kidney biopsy in a child takes the time it takes to be performed safely and effectively.

Should CMS believe that the American Medical Association's (AMA) Relative Value Scale Update Committee (RUC) process does not accurately capture technological and efficiency gains in physician practice, ASPN urges the agency to identify empiric data sources to supplement the RUC's recommendations to support the agency's policy proposals. ASPN stresses that a role for the RUC should be retained in the event the agency utilizes empiric data sources because it includes input from practicing physicians. We strongly oppose methods to value services that do not include physician input given the valuable perspectives on real-world delivery of care that physicians add to this process.

Finally, CMS structured the efficiency reduction using the MEI's productivity adjustment. ASPN believes that the agency's rationale for this choice is flawed. Unlike other Medicare fee schedules, the MPFS does not include an inflationary update. Applying a reduction based on a component of MEI, which is an inflationary measure, is inappropriate when Medicare physician reimbursement has stagnated over the last three decades because of sporadic increases to the conversion factor in the absence of inflationary updates.

The workforce crisis in pediatric nephrology is already dire. From 2014 to 2022, only 66% of pediatric nephrology fellowship training slots were filled, the lowest of all 15 pediatric

subspecialties. In 2024, fellowship applicants decreased by nearly 30% with only 29 trainees matching with programs for a fill rate of 37%.[1] Reversing this workforce trend is made even more challenging by the downward pressure on reimbursement in both Medicare and Medicaid. Pediatric nephrologists are projected to earn $750,000 less in lifetime earnings than their counterparts in general pediatrics, a strong disincentive to pursuing subspecialty training.[2] ASPN strongly urges CMS not to implement additional policies, like the efficiency adjustment, that will further erode reimbursement for the complex care our members deliver. To do so is contrary to the Administration's commitment to make America healthy again. Children with chronic kidney disease and ESKD are medically complex and the care they require is costly to the healthcare system. It should be supported through higher reimbursement and wraparound services, not further threatened by arbitrary policies lacking evidence.

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential
Rather than update each medical specialty's indirect PE per hour using the data from the recent AMA physician practice information survey, CMS proposes to retain the current medical specialty per hour valuations and instead update the indirect PE allocation by cutting the allocation for facilities in half. The agency believes that the data from the survey was flawed and that the allocation requires adjustment because most physicians no longer practice in office-based settings. This proposal significantly reduces the indirect PE inputs for the majority of services performed in the facility.

ASPN has significant concerns about this proposal. First, the agency does not provide any data to support the reallocation of indirect PE relative value units (RVUs). For a reallocation of RVUs of this magnitude, stakeholders should have the opportunity to assess the data. We do not believe that this reallocation reflects how indirect practice expenses are borne in pediatric nephrology practices. Most pediatric nephrologists practice in academic medical centers and use facility clinics; unlike in primary care pediatrics, almost none work in a private practice setting. Many of our members report paying their children's hospitals for rent of their clinic space and for clinic administrative staff. Before implementing a policy with such significant redistributive effects, the agency must ensure that it reflects how facility-based practices operate.

As stated above, children with ESKD are the only individuals under 65 years of age who are automatically eligible for Medicare based on their disease status. Typically, these children are the only Medicare beneficiaries treated in children's hospitals. Our members provide dialysis care, kidney transplant, and post-transplant care to children in this setting. We note that dialysis services typically delivered in the facility setting are not subject to the indirect PE cut because they are treated as non-facility services for rate setting purposes. Dialysis, particularly for young children, is a complex and labor-intensive service requiring the

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[1] https://www.healio.com/news/nephrology/20250207/nni0325weidemannfirstwordfinal#:~:text=During%20an%208%2Dyear%20period,a%20fill%20rate%20of%2037%25.

[2] Weidemann DK, Ashoor IA, Soranno DE, Sheth R, Carter C, Brophy PD. Moving the Needle Toward Fair Compensation in Pediatric Nephrology. Front Pediatr. 2022 Mar 10;10:849826. doi: 10.3389/fped.2022.849826. PMID: 35359890; PMCID: PMC8960267.

participation of a pediatric nephrologist, nurses, social workers, dietitians and other support staff (e.g. education specialists, psychologists, child-life specialists). This is not a service that could be performed in an office setting. Therefore, we believe the longstanding policy to treat dialysis as a non-facility service is appropriate, and it should not be subjected to this reduction.

The policy as proposed will affect the other services our members deliver even with dialysis exempted. This proposed cut comes at the same time that Congress made significant changes to the Medicaid program, which covers almost half of American children and approximately one-third of children with ESKD. Children's hospitals are being forced to determine how to continue to provide the highest quality care to medically complex children as Medicaid reimbursement shrinks. Further downward pressure on Medicare reimbursement, as would result from this policy, will result in access issues for the medically complex children our members treat. High-quality ESKD care requires the participation of a robust interdisciplinary care team, including the pediatric nephrologist and pediatric-trained nurses, social workers, dieticians, and other support staff as mentioned above. The cost of maintaining these teams is significant, and Medicare and Medicaid reimbursement already falls short in covering these costs. ASPN strongly opposes this policy and urges the agency to rescind this proposal. Should CMS want to address the indirect PE RVU allocation, we urge the agency to present relevant data to support a new proposal to allow a thorough evaluation on its potential impacts on care.

Request to Add Dialysis Services to the Medicare Telehealth Services List
CMS received a request to add acute dialysis procedures described by CPT codes 90935 (Hemodialysis procedure with single evaluation by a physician or other qualified health care professional), 90937 (Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription), 90945 (Dialysis procedure other than hemodialysis (for example, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional), and 90947 (Dialysis procedure other than hemodialysis (for example, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription) to the Medicare Telehealth Services List.

ASPN agrees with the agency that these services should not be added to the telehealth list. These codes are generally used to treat critically ill hospitalized children, like acute kidney injury or multi-organ failure, and are best treated in-person rather than virtually. Treating a stable dialysis patient virtually, as is allowed, differs significantly from treating a patient with a potentially life-threatening acute illness. It is appropriate for this distinction to be maintained by not adding CPT codes 90935, 90937, 90945, and 90947 to the telehealth list.

Request for Information on Prevention and Management of Chronic Disease
CMS requests feedback on ways to enhance support for the prevention and management of chronic diseases. As has been noted, our members provide care for children with chronic kidney disease, and we offer the following suggestions on ways that the agency could

improve reimbursement and coverage of the complex care provided for this chronic disease.

ASPN respectfully requests that CMS use this opportunity to address a longstanding challenge in delivering pediatric ESKD care by ensuring comprehensive coverage of ambulatory blood pressuring monitoring (ABPM). Although the vast majority of children with kidney disease have it due to congenital anomalies of the kidneys and urinary tract (unlike in American adults, in whom diabetes and hypertension are primary causes of ESKD), high blood pressure can worsen the condition. More than half of children with ESKD have uncontrolled hypertension despite the widespread use of hypertensive drugs.[3] ABPM has long been shown to be cost-effective in the initial evaluation of stage 1 hypertension in children.[4] Additionally, nocturnal hypertension is common in children with autosomal dominant polycystic kidney disease and in recipients of solid-organ transplants.[5]

Despite this evidence and a CMS National Coverage Determination (NCD) on the topic, our members report that challenges remain to ensure pediatric patients have access to ABPM. Therefore, we urge CMS to ensure coverage of ABPM for children with ESKD and who have received kidney transplants. ABPM provides for the collection of a child's blood pressure readings for 24 hours, which is then transmitted to the physician. This data gets uploaded into the electronic medical record and allows the pediatric nephrologist to adjust a child's care plan accordingly. This relatively inexpensive intervention allows for more effective care management for this costly patient population. Blood pressure control is one of the only interventions that has ever been shown to slow the progression of existing kidney disease in children, which can in turn delay the onset of dialysis or the need for a kidney transplant.[6]

There are 4 separate CPT codes for ABPM and two potential ways to bill these codes. The codes are 93784 (Global code for Ambulatory Blood Pressure Monitoring (ABPM), including recording, scanning analysis, interpretation, and report), 93786 (Recording only), 93788 (Scanning analysis with report), and 93790 (Physician review with interpretation and report). Providers can either bill the global code, which includes monitor placement, downloading of data and interpretation and report generation, or the provider could bill all 3 steps separately using the individual codes. The second step, downloading the data, could be considered as software as a service, which the agency also considers in this rule. The

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[3] Hadtstein C, Schaefer F. Hypertension in children with chronic kidney disease: pathophysiology and management. Pediatr Nephrol. 2008 Mar;23(3):363-71. doi: 10.1007/s00467-007-0643-7. Epub 2007 Nov 8. PMID: 17990006; PMCID: PMC2214827.

[4] Swartz SJ, Srivaths PR, Croix B, Feig DI. Cost-effectiveness of ambulatory blood pressure monitoring in the initial evaluation of hypertension in children. Pediatrics. 2008 Dec;122(6):1177-81. doi: 10.1542/peds.2007-3432. PMID: 19047231.

[5] https://www.ahajournals.org/doi/10.1161/HYP.0000000000000215

[6] ESCAPE Trial Group; Wühl E, Trivelli A, Picca S, Litwin M, Peco-Antic A, Zurowska A, Testa S, Jankauskiene A, Emre S, Caldas-Afonso A, Anarat A, Niaudet P, Mir S, Bakkaloglu A, Enke B, Montini G, Wingen AM, Sallay P, Jeck N, Berg U, Caliskan S, Wygoda S, Hohbach-Hohenfellner K, Dusek J, Urasinski T, Arbeiter K, Neuhaus T, Gellermann J, Drozdz D, Fischbach M, Möller K, Wigger M, Peruzzi L, Mehls O, Schaefer F. Strict blood-pressure control and progression of renal failure in children. N Engl J Med. 2009 Oct 22;361(17):1639-50. doi: 10.1056/NEJMoa0902066. PMID: 19846849.

agency should continue to promote and support this important service and ensure that reimbursement for each code in this family is commensurate with its value in preventing and better managing chronic kidney disease and kidney transplants in children.

Currently, Medicare does not adequately reimburse for nutrition services and follow-up nutrition counseling for children with chronic kidney disease. Nutritionists and dietitians must receive pediatric-specific training to provide care for children with kidney disease, and the limited available reimbursement is insufficient to provide adequate nutrition counseling to pediatric patients. The agency should consider expanding coverage and reimbursement of nutrition services for both the prevention and treatment of chronic conditions, including chronic kidney disease. Similarly, CMS should consider reimbursing the services provided by social workers as these professionals play a vital role in addressing the upstream drivers of health on chronic disease.

CMS should also consider improved coverage and payment for the medications and supplies needed for pediatric chronic kidney disease patients, including over the counter medications such as sodium bicarbonate, iron, vitamin D and magnesium that are critical for patients with chronic diseases. The agency should also expand the coverage for enteral nutrition supplements such as Renastart and Renastep and associated supplies including gastrostomy tubes; Infants and young children with advanced kidney disease often will not eat by mouth and require tube feedings to meet developmental milestones and grow large enough to receive a kidney transplant. The current NCDs are drafted for adult populations and do not account for the pediatric kidney disease patients who qualify for Medicare coverage.

Finally, we applaud the administration's focus on improving the quality of the food supply and urge the agency to expand coverage and reimbursement for healthy food. Many of our patients do not have access to healthy food, and there needs to be a focus on improved access to healthy food in both rural and urban areas that are food deserts. The agency should consider policies that would expand access to healthy food, including working with the U.S. Department of Agriculture on programs that incentivize farmers markets and healthier food in grocery stores.

ASPN appreciates the opportunity to offer comments on CMS' CY 2026 MPFS proposed rule. Please contact our Washington representative Erika Miller at emiller@dc-crd.com if we can provide additional information or clarification regarding these comments.

Sincerely,

Meredith Atkinson
President