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September 12, 2025

Mehmet Oz, M.D., M.B.A.

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1832-P

P.O. Box 8016

Baltimore, MD 21244-8010

RE: Medicare and Medicaid Programs; CY 2026 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; [CMS-1832-P]

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with kidney disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with kidney disease.

We are writing to provide comments on the 2026 Medicare Fee Schedule proposed rule. Our comments will address the following issues:

- **Work RVU Efficiency Adjustment**
- **Revised Indirect Practice Expense Cost Methodology**
- **Separate Payment for High-Cost Supplies**
- **Solicitation of Comment on Adding CPT Codes 90935, -37, -45-, and -47 to the Medicare Approved Telehealth List**
- **Impact of Incorrect Utilization Assumptions for G2211**
- **Revisions to the Medicare Diabetes Prevention Program**

Work RVU Efficiency Adjustment

In the proposed rule, CMS outlines concerns about the current survey process used by the AMA's Relative Value Update Committee (RUC) to develop work relative value units (RVUs), citing low response rates, inherent conflicts of interest, and time assumptions built into the valuation of many physician fee schedule (PFS) services, leading to values that are likely overinflated. As a result, the Agency proposes to apply an efficiency adjustment "to the work RVU and corresponding intraservice portion of physician time of non-time-based services that we expect to accrue gains in efficiency over time."

RPA supports the broader methodological basis for these decisions. We concur that the current system for valuation of Medicare physician services has flaws, and we also support the decision to not apply the efficiency adjustment to time-based services, as doing so would impair the ability of primary care physicians and other specialties to proactively identify, treat, and coordinate care for Medicare beneficiaries. This is particularly relevant to patients with chronic illnesses such as chronic kidney disease (CKD), for whom early detection, early treatment and proactive care coordination are key to improving patient outcomes that will also have a positive downstream effect on the Medicare Trust Fund.

Acknowledging our general support of the thought process behind the efficiency adjustment proposal, RPA is concerned about CMS' plan for its future. The rule states:

"We are proposing to update and apply the proposed efficiency adjustment with a cadence of every 3 years to align with the other updates under the PFS, including updates to the Geographic Practice Cost Index (GPCI) and Malpractice (MP) RVUs, to allow for streamlining so that interested parties can expect updates on a similar timeframe."

RPA posits that the efficiency adjustment is wholly different from the GPCI and MP updates. In contrast to those updates, which have occurred every three years for decades with finite and consistent impact on affected services, the efficiency adjustment has the potential to be substantially disruptive to the fee schedule every year it is implemented. Further, an across-the-board adjustment every three years would endanger the relativity of the fee schedule as it is very unlikely that the efficiency gains across all services are identical. More broadly, continued and in effect, incremental, downward value adjustments in the services impacted will compromise the ability of physicians in the associated specialties to maintain consistent, high-quality care to the Medicare beneficiaries they treat. While CMS does only note that this is an intended cadence, RPA urges CMS to defer definitive plans for scheduling subsequent efficiency adjustments (the next is scheduled for 2029 per the rule) until the impact on Medicare patient care can be appropriately evaluated to ensure that it is not harmful.

Revised Indirect Practice Expense Cost Methodology

Another significant proposal in the rule pertaining to valuation of physician services relates to the development of indirect practice expenses (PEs). In its fact sheet on the proposed rule CMS describes the proposal as follows:

“...we are proposing significant updates to our PE methodology to better reflect current clinical practice. Specifically, we are proposing to recognize greater indirect costs for practitioners in office-based settings compared to facility settings. The original allocation methodologies assumed physicians maintained separate practice locations even if they furnished some care in hospitals. Since the methodologies were established decades ago, there has been a steady decline in the number of physicians working in private practice, with a corresponding rise in physician employment by hospitals and health systems. Therefore, we believe that the allocation of indirect costs for PE RVUs in the facility setting at the same rate as the non-facility setting may no longer reflect contemporary clinical practice.”

In the rule itself, CMS states: “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 non-facility PE RVUs beginning in CY 2026.”

Like our stance on the efficiency adjustment discussed above, RPA acknowledges the underlying circumstances prompting CMS’ indirect practice expense proposal, and further, we recognize the Agency’s responsibility to refine policy based on shifting trends in physician practice. However, reducing the work RVU-based PE allocation by half seems like using a blunt policy instrument to address the stated concerns. There is tremendous heterogeneity in the employment agreements and work arrangements among physicians, and it is common for employed physicians to continue to be responsible for their own overhead and that the hospital does not pay for their overhead, so the proposal would be unfair to those employed physicians. Additionally, an across-the-board cut in indirect costs will significantly impact clinicians who care for patients in both inpatient and outpatient care settings. For example, many nephrologists provide care in both settings, so such a sweeping reduction does not reflect the reality of physician practice. In other words, for many providers, administrative and support staff continue to support patients, regardless of the venue in which a provider sees patients. These staff are often aiding in care transitions, follow-up scheduling, and various activities that aim to avoid rehospitalization and complications. We suggest a more nuanced approach to addressing the shifting trends in physician practice in future rulemaking. CMS should consider use of a process where specialties can request that a code be exempt from a reduction, if this proposal is finalized.

Separate Payment for High-Cost Supplies

RPA shares the concern of other physician specialties regarding the impact of high-cost

supplies included among PE inputs in the fee schedule on Medicare physician reimbursement. Given that the cost of equipment and supplies are a payment input over which physicians have no control, RPA has long supported efforts among the broader organized medicine community to advocate for separate payment for high-cost supplies. As such, we appreciate CMS soliciting stakeholder input on either creating G-codes to describe the use of high-cost supplies, or potentially using data sources such as the Hospital Outpatient Prospective Payment System (OPPS) mean unit cost data (MUC) and/or Ambulatory Payment Classification (APC) relative weights to determine the pricing of high-cost supplies and equipment in the fee schedule. By whichever refinement process, RPA urges CMS to urgently address the issue of how the inclusion of high-cost supplies impacts Medicare fee schedule payment more broadly.

Solicitation of Comment on Adding CPT Codes 90935, -37, -45-, and -47 to the Medicare Approved Telehealth List

In the proposed rule, CMS notes that it received a request to add dialysis procedures described by CPT codes 90935, 90937, 90945, and 90947 (hemodialysis procedures with either a single or repeated evaluation(s) by a physician or other qualified health professional) to the Medicare Telehealth Services List. Typically, these procedures occur on an inpatient basis but not always. The rule goes on to state that these codes describe reviewing medical records, obtaining an interval history, performing an expanded problem- focused or detailed physical examination, formulating and/or revising diagnosis and treatment plan(s)(moderate or high complexity medical decision-making), and discussing diagnosis and treatment. On either a single or two or more visits, the practitioner assesses the patient and their response so far to dialysis, writes and/or reviews orders, and supervises dialysis.

RPA supports the use of telehealth and other evolving technologies for many Medicare-covered services and believes in its potential to expand access to care for all kidney patients. However, CPT codes 90935, -37, -45, and -47 all typically describe services provided to hospitalized patients who are acutely ill and in most cases require a face-to-face visit. This contrasts with the services represented by the outpatient dialysis codes (CPT codes 90951-90970), which are typically provided to patients who, while still chronically ill, are outpatients and more stable than those receiving care via the CPT code 90935-47 code set. RPA does recognize that there would be value in the 90935-47 code set being available for care provided by telehealth in rural settings, and if there were an exclusion process that would limit its use to care provided in rural settings, that would be reasonable and appropriate. Otherwise, we do not believe that CPT codes 90935, -37, -45, and -47 should be added to the Medicare Telehealth Services List.

Impact of Incorrect Utilization Assumptions for G2211

G-code G2211 was implemented as part of the 2024 Medicare Fee Schedule, after being proposed for the 2019 fee schedule but then being delayed by Congress. RPA fully supports the use of G2211 (for use when there is a longitudinal relationship between the physician or advanced practitioner and patient, and the physician/APP serves as the continuing focal point

for medical services that are part of ongoing care) as it substantially facilitates coordination of care to patient with chronic illnesses like CKD. We believe it is an innovative and visionary policy lever through which CMS can promote enhanced care to vulnerable Medicare beneficiaries.

That said, we share the concerns of the AMA and organized medicine broadly that the utilization assumptions developed in advance of the 2024 implementation were significantly overestimated and have artificially inflated the baseline for the conversion factor (CF), to the detriment of physician reimbursement. The utilization assumption used for the 2024 fee schedule was 38%, 350% higher than the actual 10.5% utilization rate determined from AMA's analysis of Medicare claims data for the first three quarters of 2024. RPA therefore strongly urges CMS to implement a correction in the utilization assumptions via a budget neutrality adjustment to the 2026 CF.

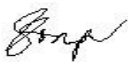
Revisions to the Medicare Diabetes Prevention Program

CMS proposes in the rule to expand access to the Medicare Diabetes Prevention Program (MDPP) by: (1) increasing coverage for on-demand (asynchronous), online delivery of MDPP; (2) revising weight collection requirements to allow beneficiaries to self-report their weight from a reasonable location or submit as part of a medical record; and (3) allowing MDPP suppliers to deliver some or all MDPP sessions via distance learning by extending COVID-19 flexibilities, among other revisions.

RPA commends the Agency for seeking innovative pathways to identify and reach Medicare beneficiaries with Type 2 diabetes to potentially delay progression of the condition. Given the wide prevalence of diabetes (and its presence as a major precursor to kidney disease), the potential health advantages these proposals could provide to Medicare beneficiaries (and the possible upside to the Medicare program fiscally) more than justifies their finalization.

As always, RPA welcomes the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation's kidney patients, and we stand ready as a resource to CMS in its future work on the Medicare Fee Schedule. Any questions or comments regarding this correspondence should be directed to RPA's Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.

Sincerely,



Gary Singer, M.D.
RPA President

CC: Adonia Calhoun Groom, RPA Executive Director

