



February 25, 2025
Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20001

Re: Contract Year 2027 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and MA and Part D Payment Policies

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 Contract Year 2027 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and MA and Part D Payment Policies.

Currently, nearly 850,000 Americans have kidney failure (i.e. End-Stage Renal Disease or ESRD), including more than 550,000 receiving chronic dialysis and nearly 300,000 living with a kidney transplant. Chronic kidney disease (CKD) is a progressive condition most often characterized by the gradual loss of kidney functionⁱ. It affects approximately 37 million Americans, or about 1 in 7 adults, and its prevalence is projected to riseⁱⁱ. 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 aloneⁱⁱⁱ. ASN believes that it is essential as a nation to reduce the burden of kidney diseases on individuals, their families, and the health care system overall. This mission aligns with the Trump Administration's chronic disease prevention efforts to Make America Healthy Again (MAHA).

Prior to 2021, Medicare beneficiaries with incident kidney failure were not allowed to enroll in Medicare Advantage (MA) plans. Medicare beneficiaries who were already enrolled in MA plans when they developed kidney failure were allowed to remain in that plan; however, if they left MA, they could not re-enroll. This prohibition was changed when Congress passed the bipartisan 21st Century Cures Act (Cures Act; P.L. 114-225), which allowed beneficiaries with an ESRD diagnosis to enroll in MA beginning January 1, 2021. Following the passage of the 21st Century Cures Act, enrollment of patients with ESRD in MA plans has increased substantially, with MA enrollment estimated to have surpassed 54% of Medicare-eligible ESRD beneficiaries receiving dialysis in 2025.

Individuals with kidney disease may choose to enroll in MA plans for several reasons. MA plans may offer enhanced care coordination and supplemental benefits such as dental, vision, and transportation services that are not available under traditional Medicare. In addition, MA plans include annual out-of-pocket maximums, which can be particularly important for dialysis patients who often do not have access to Medigap coverage. However, despite potential advantages, patients with ESRD enrolled in MA plans frequently face significant barriers to care, including restricted provider networks and prior authorizations requirements. Many MA plans also impose

large early-year deductibles, which can create substantial financial pressure for patients during the first months of the year even if costs even out over time. Furthermore, many MA plans restrict access to innovative therapies and technologies by refusing to recognize or “slow-walking” the Transitional Drug Add-on Payment Adjustment (TDAPA) and the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES). These limitations may result in MA enrollees not having access to the same services and items available to traditional Medicare beneficiaries despite mandates to the contrary.

Kidney transplantation is widely considered the optimal therapy for most patients with ESRD; however, evidence suggests that MA enrollment may be associated with reduced access to transplantation. Available studies indicate that MA enrollees are 18–24% less likely than traditional Medicare beneficiaries to be placed on a deceased donor kidney transplant waitlist within one year of dialysis initiation^{iv}. This disparity is concerning because delayed or limited access to transplantation can result in worse patient outcomes and higher long-term costs.

As more Americans living with kidney diseases enroll in MA plans, it is essential to monitor and evaluate how proposed policy changes may affect their access to care, treatment options, and overall health outcomes. In light of these considerations, ASN offers the following comments on aspects of the proposed rule that are most relevant to individuals living with kidney diseases.

ASN Commends CMS’s Proposal to Refine HCC Risk Adjustment to Reflect CKD Severity

ASN strongly supports CMS’s proposal to recognize the tremendous heterogeneity within CKD stages by removing the coefficient constraint between HCC 328 (Chronic Kidney Disease, Moderate, Stage 3b) and HCC 329 (Chronic Kidney Disease, Moderate, Stage 3, Except 3b) in the proposed 2027 CMS Hierarchical Condition Categories (HCC) Risk Adjustment Model.

Allowing separate coefficients will improve the accuracy of MA risk adjustment, ensure more appropriate risk stratification of beneficiaries with CKD, and direct payments more precisely to plans that enroll a higher proportion of CKD Stage 3b members who face greater risks of utilization and disease progression. Many patients with CKD stage 3b have high-risk kidney disease and are at high likelihood of progressing to more advanced CKD and kidney failure. This change also reinforces the importance of accurate documentation of CKD stage, which is essential to ensuring payment reflects true clinical severity, consistent with the far greater impact of CKD stage G3b than CKD stage G3a on overall health and medical complexity. Overall, removing the constraint strengthens the predictive accuracy and payment integrity of the MA program.

In addition, ASN is reviewing the opportunity to increase the specificity of kidney-related HCC coding, to better capture the complexity of patients with kidney disease conditions and inform clinical practice. For example, HCC coding specifying macroalbuminuria (severely elevated albuminuria) can improve prediction of patients most likely to have progressive CKD and benefit from therapies like sodium-glucose cotransporter 2 (SGLT-2) inhibitors, GLP1-related therapies, mineralocorticoid receptor antagonists, and other disease-specific treatments.

ASN further encourages CMS to make a parallel update to the Prescription Drug Hierarchical Condition Category (RxHCC) model by adopting separate coefficients for HCC 328 and HCC 329. Patients with CKD Stage 3 also have higher prescription drug costs than the average Medicare beneficiary. Distinguishing within the CKD stage 3 within the RxHCC framework would improve payment accuracy, better anticipate medication expenditures, and promote methodological consistency across Medicare Advantage payment systems.

ASN Continues to Express Concern Regarding MA Data Collection and Transparency

Although not addressed in this proposed rule, ASN continues to urge CMS to provide greater transparency regarding data on individuals enrolled in MA plans and those who are receiving dialysis. We urge CMS to require MA plans, which cover close to 50 percent of all Medicare beneficiaries, including many individuals dually eligible for Medicaid and Medicare, to report the same data that are reported through traditional Medicare. The Medicare ESRD program has a strong history of providing quality and other clinical and administrative data to support payment reform and monitor patient outcomes. The Medicare Payment Advisory Commission (MedPAC) has reported that MA encounter data, while improving, are still not complete^v. The loss of data on care delivery patterns and outcomes for this growing population could lead to gaps in care, quality outcomes, innovation, and payment updates.

As mentioned in the opening of this letter, kidney transplantation is widely considered the optimal therapy for most patients with ESRD; however, evidence suggests that MA enrollment may be associated with reduced access to kidney transplant. Although kidney transplant outcomes in MA have not been well-described, studies found MA enrollees were 18-24% less likely than traditional Medicare enrollees to be placed on a deceased donor kidney transplant waitlist by 1 year following dialysis start date^{vi}. These findings raise concerns about the potential barriers to transplant access within the MA program and underscore the need for CMS to strengthen data collection, reporting, and transparency related to transplant referral, waitlisting, and outcomes among MA enrollees.

Conclusion

ASN appreciates the opportunity to comment on these proposals from CMS. ASN supports CMS's efforts to refine risk adjustment methodology so that MA payments more accurately reflect clinical severity and expected costs for patients with kidney diseases. Greater data transparency and completeness are also critical for ensuring payment policies are grounded in reliable evidence and that beneficiary access and outcomes can be effectively evaluated. ASN looks forward to continued collaboration with CMS to advance policies that improve the Medicare Advantage program for patients with kidney diseases. To discuss this letter further, please contact Lauren Ahearn, ASN Policy and Government Affairs Coordinator, at lahearn@asn-online.org.

Sincerely,



Samir M. Parikh, MD, FASN
President

ⁱ <https://www.mayoclinic.org/diseases-conditions/chronic-kidney-disease/symptoms-causes/syc-20354521>

ⁱⁱ <https://www.niddk.nih.gov/health-information/health-statistics/kidney-disease>

ⁱⁱⁱ US Renal Data System. 2023 USRDS Annual Report: Epidemiology of Kidney Disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. Bethesda, MD. 2023. <https://usrds-adr.niddk.nih.gov/2023/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd>

^{iv} iv Adler JT, Kuk AE, Drewry KM, Nguyen KH, Wilk AS. Implications of Increased Medicare Advantage Enrollment for Access to Kidney Transplant Waitlisting. *Journal of the American Society of Nephrology*. 2025;36(6):1173. doi:10.1681/ASN.00000006672022;3(10):e223451.

^v https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf

^{vi} Adler JT, Kuk AE, Drewry KM, Nguyen KH, Wilk AS. Implications of Increased Medicare Advantage Enrollment for Access to Kidney Transplant Waitlisting. *Journal of the American Society of Nephrology*. 2025;36(6):1173. doi:10.1681/ASN.00000006672022;3(10):e223451.