January 26, 2026
The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20001

Re: CMS-4212 -P: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program 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 CMS-4212-P: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program Proposed Rule.

Currently, more than 800,000 Americans have kidney failure (i.e. End Stage Renal Disease or ESRD), including more than 550,000 receiving chronic dialysis and more than 200,000 living with a kidney transplant. Chronic kidney disease (CKD) is a progressive condition most often 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 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[iii]. 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 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 in 2025.

Individuals with kidney disease may choose to enroll in MA plans for several reasons. MA plans often 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 these 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 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. Although transplant outcomes and access in MA have not been well-described, 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.

Below, we list specific proposed rule changes and how these changes may affect care for patients with kidney disease, with specific focus on the ESRD population.

Medicare Advantage Star Program Updates

Removal of Measure C-07 Special Needs Plan (SNP) Care Management measure from the Medicare Advantage Stars Program

ASN opposes CMS's proposal to remove the Special Needs Plan (SNP) Care Management measure (C-07) from the 2027 Star Ratings.

Medicare Advantage Special Needs Plans (SNPs) are specialized MA plans designed to serve beneficiaries with specific chronic conditions, complex care needs, or dual eligibility for Medicare and Medicaid. SNPs are intended to improve care coordination and outcomes for populations with higher medical and social needs, including

individuals with ESRD. Beginning in 2026, CMS is expanding the C-SNP condition category to include chronic kidney disease (CKD), allowing plans to serve patients across the full kidney disease continuum. Early evidence from Powers et al. demonstrated that enrollment in SNPs among beneficiaries with ESRD was associated with lower mortality, inpatient and skilled nursing facility utilization, indicating that resources provided by SNPs such as care coordination could be impactful for this vulnerable population[v].

Measure C-07 specifically assesses the percentage of eligible SNP enrollees who received a health risk assessment during the measurement year. While this measure does not fully capture care management effectiveness for patients with kidney disease or ESRD, it provides transparency into whether SNPs are engaging and coordinating care for a clinically complex ESRD population. ASN strongly encourages CMS to retain Measure C-07 for the 2029 Star Rating Year and beyond, and to stratify the measure to include CKD-specific and ESRD-specific reporting.

Removal of Measure C-09: Diabetes Care-Eye Exam
ASN opposes the removal of this metric that measures the percentage of diabetic MA enrollees age 18-75 with diabetes (type 1 and type 2), who had an eye exam (retinal) performed during the measurement year (numerator). As nephrologists who care for patients with diabetes related complications not limited to kidney disease, we witness first-hand the burden of disease related to diabetic retinopathy and recognize the importance of yearly screenings. Inclusion of this measure can support resourcing by MA plans to ensure adequate reimbursement for and access to critical ophthalmologic care for diabetic patients (many of whom are beneficiaries with CKD). Currently, patients with ESRD are excluded from this measure given ESRD is considered an advanced illness; however, this may not be appropriate for all patients and should be reexamined as an exclusion criterion[vi]. Data suggests that sight-threatening diabetic eye disease is much more common in patients with advanced CKD and ESRD; however, eye screening rates in 2023 remained less than the 47% rate if screening prior to 2020[vii]. Although there are other measures related to diabetes care, this metric is distinct in terms of enablement of specific care delivery related to retinal screening.

Removal of Measure C-19 Statin Therapy for Patients with Cardiovascular Disease
ASN opposes the removal of this metric that measures the percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high or moderate-intensity statin medication during the measurement year. Patients with CKD are at high risk for adverse cardiovascular outcomes, and statin use has been shown to improve outcomes among patients with CKD, in particular[viii]. Further, ASN urges CMS to include CKD as a qualifying condition for cardiovascular disease in *Measure C-19 Statin Therapy for Patient with Cardiovascular Disease.* CKD has a well-established role as an independent

cardiovascular risk factor. CKD significantly increases risk for coronary artery disease, heart failure, arrhythmias, sudden cardiac death, and cardiovascular mortality, which often exceeds progression to kidney failure in advanced CKD[ix]. Consistent with this evidence, KDIGO recommends statin therapy for adults aged ≥50 years with non-dialysis CKD, including statin or statin/ezetimibe for those with eGFR <60 mL/min/1.73 m² (GFR categories G3a–G5) and statin therapy for those with eGFR ≥60 mL/min/1.73 m² (GFR categories G1–G2)[x].We recognize that there are other measures related to statin use, for example, the "Medicare Adherence for Cholesterol (Statins)", Part D measure. However, given the importance of ensuring statin therapy is initiated, and that "Medicare Adherence for Cholesterol (Statins)" is a Part D plan-only measure, ASN is strongly in favor of maintaining the measure for CKD.

Removal of Measure C-29: Members Choosing to Leave the Plan
Measure C-29: Members Choosing to Leave the Plan captures the percentage of members who disenroll from a Medicare Advantage (MA) contract, based on disenrollment reason codes in Medicare's enrollment system. This measure is particularly important for patients with CKD and ESRD, a population for which there has historically been limited knowledge regarding managed care despite rapid growth in MA enrollment. Between 2021 and 2022, approximately 30% of MA enrollees with ESRD switched plans, highlighting the turnover and unique needs of this population[xi]. Given this growing and clinically complex population, understanding how many ESRD patients choose to leave MA plans is a critical data point for beneficiaries as they evaluate plan options and for CMS as it monitors patient experiences, outcomes, and the effectiveness of MA plans in managing ESRD care. Accordingly, ASN recommends that CMS maintain Measure C-29 and strongly consider stratifying the measure for ESRD patients to ensure meaningful oversight and transparency for this high-need population.

ASN has concerns about the removal of the Annual Health Equity Analysis of Utilization Management Policies and Procedure

The CY2025 Medicare Advantage and Part D Final Rule (CMS-4205-F) requires MA plans to establish a Utilization Management (UM) Committee that annually reviews all UM policies, including prior authorization, to ensure they are consistent with Medicare coverage requirements and with current national and local coverage determinations[xii]. In addition, there is a requirement to conduct and publicly post an annual health equity analysis that evaluates the impact of prior authorization on enrollees with specified Social Risk Factors (SRFs), defined as 1) receipt of the Low-Income Subsidy (LIS) or dual eligibility for Medicare and Medicaid and 2) disability status. The current proposal is to remove these requirements. ASN has concerns about this approach, given the disproportionate impact of ESRD and CKD on patients with established SRFs, particularly, individuals residing in rural counties who often face compounding social risk factors such as limited access to specialty care, transportation barriers, and workforce shortages. These factors may further exacerbate disparities in the application of UM policies, particularly related to kidney-related care delivery. We strongly encourage

CMS to monitor MA plan UM policies and application to beneficiaries with ESRD, CKD and SRFs.

ASN supports the proposed modifications to provide individuals with more flexibility to access Special Enrollment Periods (SEPs)

SEPs are crucial for ESRD MA enrollees because they allow mid-year plan changes for significant life events. Such flexibility is especially important when MA plan networks exclude essential dialysis centers or transplant centers. These exclusions often disrupt care and lead to negative patient outcomes. In addition, SEPs can allow patients to avoid gaps in vital and complex kidney care. SEPs provide an important mechanism to support these enrollees when initial plan choices prove inadequate to support their medical needs

ASN supports the proposed modifications that would allow enrollees to change plans when one or more of their providers leave their plan's network. We encourage consideration of policies that allow dialysis patients to receive care at facilities where their nephrologists practice. Continuity of care and established patient–physician relationships are particularly relevant for individuals receiving dialysis, given the complexity of their care needs. We also support removing the current limitation that requires MA organizations and CMS to deem the network change to be "significant." We encourage CMS to finalize both policies as proposed.

ASN Continues to Express Concern Regarding MA Data Collection and Transparency

Although not addressed in this proposed rule, ASN asks that CMS 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 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[xiii]. 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.

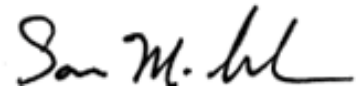
As mentioned in the opening of this letter, kidney transplantation is widely considered the optimal therapy for most patients with ESRD; however, evidence suggests that MA enrollment may be associated with reduced access to kidney transplant. Although kidney transplant in MA has not been well-described, 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[xiv]. 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 recognizes that with the growth of ESRD beneficiary enrollment in MA plans, there is need for increased scrutiny on the quality of care delivered, particularly related to the implementation of the Stars Rating program. Measures in the Stars Rating program impact the resourcing of MA plans to impact care delivery and health outcomes. ASN will be engaging with CMS over the next few months to provide comprehensive feedback on existing measures, as well as recommendations regarding further opportunities to examine and influence the quality of care. 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.healthaffairs.org/doi/10.1377/hlthaff.2019.01793?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed)

[vi] Cushley LN, Quinn NB, Blows P, McKeever E, Peto T. The Integration of Diabetic Eye Screening into Hemodialysis Units in Northern Ireland. Kidney360. 2022 May 18;3(9):1542-1544. doi: 10.34067/KID.0001802022. PMID: 36245648; PMCID: PMC9528388

[vii] https://usrds-adr.niddk.nih.gov/2025/end-stage-renal-disease/2-clinical-indicators-and-preventive-care

[viiiviii] https://pubmed.ncbi.nlm.nih.gov/21095263

[ix] https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.120.050686

[x] https://kdigo.org/wp-content/uploads/2024/03/KDIGO-2024-CKD-Guideline.pdf

[xi] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2823636

[xii] https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f

[xiii] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf

[xiv] 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.