American Society of Nephrology

January 6, 2026
Partnership for Quality Measurement
c/o Battelle
901 D Street, SW
Suite 900
Washington, DC 20024

Dear Pre-Rulemaking Measure Review Staff and Committee:

RE: Comments on 2025 Measures Under Consideration (MUC) List ESRD Measures

On behalf of the more than 37,000,000 Americans living with kidney diseases and the nearly 22,000 nephrologists, scientists, and other kidney health care professionals who are members of the American Society of Nephrology (ASN), thank you for the opportunity to provide comments on the 2025 Measures Under Consideration (MUC) list.

Currently, more than 800,000 Americans have kidney failure, including more than 550,000 receiving chronic dialysis and more than 200,000 living with a kidney transplant. ASN greatly appreciates the Partnership for Quality Measurement's (PQM's) efforts to solicit input on measures under consideration during the pre-rulemaking process to ensure the voices and perspectives of those impacted by Centers for Medicare & Medicaid Services (CMS) programs and measures are considered. ASN offers the following comments on the three ESRD-related measures under consideration.

MUC2025-011 Dialysis Facility Discussion of Life Goals

ASN recognizes the importance of delivering patient-centered care, and the society applauds CMS for its recognition of assessing patient life goals, which is an important aspect of quality of life. However, ASN has several concerns with the measure as presented that would need to be addressed before the society is able to offer our support of its use in the ESRD QIP. As currently written, ASN cannot support its inclusion in the Medicare End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP).

ASN notes that key technical specifications of the measure were not readily available for stakeholder review. In particular, the six survey questions referenced in the documentation were not provided by the Partnership for Quality Measurement (PQM). Without access to the full survey instrument, stakeholders cannot adequately evaluate the measure or provide meaningful input. In addition, testing of validity and reliability is

not available at the facility level, which is another missing component that should be available to review prior to consideration of this measure for implementation.

The “MUC2025-011 Dialysis Facility Discussion of Life Goals” measure is not endorsed by a consensus-based entity. In its 2023 endorsement review, the measure failed to receive endorsement because it did not meet the required importance and evidence criteria, which are must-pass elements. ASN maintains that measures should receive endorsement before being adopted into the ESRD QIP.

The measure is not tied to actionable interventions and, thus, may not facilitate meaningful improvements for patients receiving dialysis. Capturing patient life goals without requiring follow-up action (i.e. referral to behavioral health, social work resources, or palliative care) to support these goals limits the measure’s ability to advance meaningful, patient-centered outcomes and does not align with CMS’s Meaningful Measures 2.0 initiative. Additionally, the measure does not account for instances where patient life goals may not align with evidence-based practice, creating potential tension between respecting patient preferences and ensuring high-quality clinical care (i.e., if a patient wishes to continue receiving dialysis for life sustaining care but states their life goals are consistent with shorter dialysis treatments, that may compromise dialysis adequacy).

Without linkage to high-quality communication and care adjustments, the PaLS survey risks becoming a “check-box measure” rather than driving substantive improvements in patient centered care. No current evidence exists that implementing life goals surveys in the dialysis population leads to improvements in communication, patient experience, patient well-being, or healthcare quality.

ASN is concerned that adding an additional survey requirement in the dialysis setting will worsen survey fatigue and undermine data validity. Patients receiving dialysis are already expected to complete the following surveys: a clinical depression questionnaire (e.g., PHQ-2/PHQ-9); Kidney Disease Quality of Life (KDQOL); ICH-CAHPS (twice a year); Patient Activation Measure (PAM) for Kidney Care Choices participants; dialysis facility specific surveys, such as wellness surveys, as well as CAHPS surveys every time they are discharged from a facility or have a procedure. Consistent with these concerns, testing conducted by the University of Michigan Kidney Epidemiology Cost Center (UM-KECC) yielded a response rate of 7%, with UM-KECC noting an “overall sense of survey fatigue present in the dialysis environment”. Furthermore, some elements may be redundant with the ICH-CAHPS surveys, which asks “In the last three months, how often did your kidney doctors explain things in a way that was easy for you to understand?[i]”

The measure submission lacks adequate discussion of administrative burden. It does not describe the resources required for training, data collection, or reporting, nor does it specify a minimum reporting threshold. In addition, full incorporation of the measure into the ESRD QIP would require integration into the End-Stage Renal Disease Quality

Reporting System (EQRS), which would necessitate extensive lead time following the release of detailed technical specifications to support batch submission. Absent this information and planning, facilities cannot adequately assess feasibility or operational impact.

For these reasons, ASN has significant reservations regarding implementation of MUC2025-011 Dialysis Facility Discussion of Life Goals as outlined. ASN is open to partnering with CMS on further refinement of this measure.

MUC2025-020 Advance Care Planning (ACP)

ASN recognizes the importance of advance care planning in preparing patients receiving dialysis and their loved ones for end-of-life decisions and supports the concept of a quality measure that encourages this practice. However, ASN has several concerns with the measure as currently specified that need to be addressed before the society could consider offering support. As currently written, ASN cannot support its inclusion in the ESRD QIP.

The measure, as currently specified, has been constructed for and primarily utilized in inpatient hospital settings, as it is triggered by inpatient hospitalizations and requires documentation in the electronic health record by the time of hospital discharge. The key challenge for dialysis facilities is that many do not have interoperable data systems to access these records. In addition, there are no standardized transition of care documentation requirements between inpatient facilities and dialysis facilities, making accurate reporting and implementation of this measure in the ESRD QIP highly challenging.

ASN is concerned that the measure's patient population is defined as age 18 and older. The MIPS version of this measure sets the age threshold at 65, although these discussions may be relevant for patients with ESRD at earlier ages. Alternatively, rather than using age alone, it may be more appropriate to target the measure to patients with frailty or other markers of advanced illness to ensure the measure is clinically meaningful, patient-centered, and appropriate.

MUC2025-064 Facility Level of Chronic Hyperphosphatemia in Dialysis Patients

ASN recognizes that including phosphate-lowering medications in the prospective payment system may justify the development of a quality measure. However, ASN cannot support the measure in its current form due to concerns about the robustness of the evidence and the potential for unintended consequences. ASN offers additional considerations below.

The proposed metric relies on observational data and expert opinion with regards to serum phosphorus level thresholds rather than robust clinical trial evidence. No published trials have definitively shown that pharmacological lowering of serum phosphate to below the proposed threshold leads to improved clinical outcomes for patients. In practice, some patients have elevated phosphate levels above 6.5 mg/dL for

periods of time due to improvements in dietary intake, which should not be discouraged. At a minimum, CMS should consider a higher threshold and exclusion criteria for patients with established nutritional challenges.

ASN notes that serum phosphate levels are influenced by multiple non-medication and non-diet related factors, most notably the timing of the hemodialysis session relative to phosphate measurement. For example, phosphate levels will be higher after the long interval for patients with labs assessed on Mondays than they will be after shorter interdialytic intervals. Additionally, a phosphate level drawn immediately after hemodialysis will be much lower than a phosphate level assessed pre-hemodialysis.

ASN highlights the recent HiLo trial[ii], which was stopped early. In this trial, which possessed clinical equipoise during the design phase, the high target was a serum phosphate level of >=6.5 mg/dL and the low target was <5.5 mg/dL. The HiLo trial suffered from recruitment issues and a failure to achieve sufficient separation between groups. Within those limitations, over a too brief follow-up of 1.4 years, no signals of any differences in clinical outcomes existed between groups.

While it is not possible to draw strong conclusions from this trial, it is safe to say that this trial could not have occurred if the proposed metric were in place. In Australia, a trial of 3600 dialysis patients is underway that will assess a target phosphate threshold of <4.6 mg/dL to a more relaxed target of ~ 6.2-7.7 mg/dL (NCT03573089)[iii]. ASN eagerly awaits this trial to learn more about appropriate phosphate targets in hemodialysis patients, again emphasizing that, within the proposed metric, this trial also could not be conducted.

Hyperphosphatemia is influenced by multiple factors outside a dialysis facility's control, including patient adherence and preferences, medication tolerability, timing with meals, and dietary behaviors. As a result, strict biochemical targets, such as the one proposed in the measure, may not be appropriate for all patients. While ASN recognizes CMS's rationale for proposing this measure given the clinical risks associated with inadequately managed hyperphosphatemia, including potential cardiovascular complications, ASN believes that a medication prescribing and adherence based measure for phosphate lowering therapies would better reflect quality of care than a serum phosphate threshold. Such measures would assess whether facilities are providing guideline-consistent, actionable care without imposing rigid biochemical targets. Medication adherence measures are already used in CMS programs, such as the Medicare Advantage Stars D08 Medication Adherence for Diabetes measure, demonstrating that adherence-based measures are feasible and scalable.

Conclusion

ASN appreciates the work of both PQM and CMS. The society's membership, leaders, staff, and I stand ready to work through the details of any of these comments. To discuss this letter further, please contact Lauren Ahearn, ASN Policy and Government Affairs Coordinator, at lahearn@asn-online.org.

Sincerely,

Tod Ibrahim
ASN Chief Executive Officer and Executive Vice President

---

[i] https://ichcahps.org/Survey-and-Protocols
[ii] https://pubmed.ncbi.nlm.nih.gov/33279558/
[iii] https://clinicaltrials.gov/study/NCT03573089