NATIONAL KIDNEY FOUNDATION®

30 E. 33rd Street
New York, NY 10016
212.889.2210

January 26, 2026

Re: **Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program**

Dear Administrator Oz,

The National Kidney Foundation (NKF) is pleased to submit comments on the Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program. Our purpose is to both respond to the immediate provisions of the proposed rule for 2027 also highlighting areas where NKF is actively advancing patient-centered quality measurement and care improvement relevant to Medicare Advantage and Part D beneficiaries.

NKF recognizes that Medicare Advantage is an important coverage option for many people living with kidney disease, including individuals with chronic kidney disease (CKD), end-stage renal disease (ESRD), and kidney transplant recipients, and that MA plans can offer meaningful benefits such as care coordination, supplemental services, and annual out-of-pocket limits. At the same time, kidney patients, specifically those living with ESRD, often have highly specialized care needs and face significant medication and treatment costs that can make them especially sensitive to plan design and coverage changes. We support Medicare beneficiaries having meaningful choices in how they receive their coverage and care. We are generally supportive of innovation in Medicare Advantage but want to ensure that no beneficiary is negatively affected by future changes.

Medicare Part D Redesign Implementation

NKF supports codifying the elimination of the coverage gap phase, establishing a reduced annual out-of-pocket threshold, removing cost sharing for enrollees in the catastrophic phase, and implementing the Manufacturer Discount Program. These regulations will meaningfully benefit patients and help to make costs consistent and manageable. However, we urge CMS to monitor and mitigate unintended consequences for high-cost patients, including kidney (ESRD) patients. CMS needs to ensure that plans do not impose restrictions such as narrower pharmacy networks, step therapy, increased prior authorization requirements in response to codifying these regulations.

NKF also supports codifying the operational changes including updates to True Out-Of-Pocket (TrOOP) cost calculations, specialty-tier rules, reinsurance payment methodologies, and implementation of the Selected Drug Subsidy, but we implore CMS to ensure these changes are accompanied by well-developed (plain language, culturally/linguistically appropriate, etc.) beneficiary communications. Patients will need to have certainty about how these changes will impact their drug costs, especially if they, like many kidney patients, depend upon a high number of medications. Confusion or misinterpretation of benefit changes can lead to medication non-adherence or delayed treatment, outcomes that are especially dangerous for patients with kidney disease and transplant recipients.

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Updates to Star Ratings

NKF is supportive of the proposal to remove measures from the Star Ratings system that focus on administrative processes. We agree some of these measures lack meaning for patients, reflect internal plan processes rather than care delivery, and do not meaningfully distinguish performance between plans. However, we oppose the removal of measure C-07:Special Needs Plan (SNP) Care Management and C-29:Members Choosing to Leave the Plan.

Measure C-07 is important for ESRD and CKD patients because it provides transparency into whether Special Needs Plans are engaging beneficiaries and conducting the foundational care coordination activities required for medically complex populations.

Measure C-29 provides beneficiaries with insight into plan performance and stability, particularly for high-need populations. We recommend CMS keep this measure and amend it to stratify for ESRD patients to allow kidney patients to understand how a plan performs for beneficiaries like them.

We agree that the Star Rating system would be better served by measures that patients understand and provide greater clarity on the actual performance of the plan, but this goal should not be achieved at the expense of removing measures that provide meaningful insight into care coordination, patient experience, or plan performance for high-need populations.

NKF is opposed to the decision not to implement the Excellent Health Outcomes for All reward (previously called the Health Equity Index reward). The MA Star Ratings are important incentives that encourage plan designs that meet beneficiary needs. The Excellent Health Outcomes for All measure would be an opportunity to encourage plan designs that meaningfully meet the needs of high-need populations, rather than offering benefits that appear adequate on paper but fall short in practice. For example, ESRD beneficiaries continue to increasingly select Medicare Advantage plans over traditional Medicare. ESRD beneficiaries have unique needs, many of which supplemental benefits are well suited to. However, high needs populations like ESRD require targeted supplemental benefits, like transportation. Many transportation benefits cap rides at a level insufficient for ESRD beneficiaries who require frequent dialysis treatments, leaving patients without a realistic option for accessing care once the benefit is exhausted. CMS has limited tools to ensure oversight over supplemental benefits beyond the annual bid review and approval process. The Excellent Health Outcomes for All measure is a critical opportunity to incentivize optimal outcomes for all beneficiaries with the greatest unmet needs.

Special Enrollment Periods (SEPs)

NKF supports the proposed modifications to provide individuals with more flexibility in SEPs. Given the high level of plan changes among ESRD beneficiaries, additional mid-year flexibility is particularly important for kidney patients who may experience disruptions in access to dialysis providers, transplant centers, or transplant-related services. Enhanced SEP flexibility can help ensure continuity of care, especially for beneficiaries pursuing kidney transplantation.

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RFI: Future Directions in MA (Risk Adjustment and Quality Bonus Payments)

NKF implores CMS to consider aligning payment and quality incentives with early detection and slowing progression of chronic diseases, including Chronic Kidney Disease (CKD). Additionally, payment and quality incentives should be aligned with better care coordination. NKF also recommends that CMS address the lack of risk adjustment for CKD stages 3a and 3b. As disease knowledge has progressed, the differences between these stages have become more well understood and show a clear need for independent risk adjustment. Appropriate risk adjustment at earlier stages of CKD would better align Medicare Advantage incentives with prevention, progression slowing, and long-term cost avoidance.

NKF urges CMS to remain cognizant of how risk adjustment and quality bonus rules can impact high-cost beneficiaries, like kidney patients. Plan incentives surrounding enrollment and care need to remain stable throughout any future changes.

As CMS considers future directions for Medicare Advantage risk adjustment and quality bonus payments, NKF encourages alignment around emerging quality measure concepts for CKD and cardio-kidney-metabolic (CKM) conditions that reflect meaningful care delivery and outcomes for patients. We recognize that Medicare Advantage plan measures must be claims-based and administratively feasible for health plans. NKF is advancing quality measure development for several measures that build on Kidney Health Evaluation. CMS adopted the health plan version of the measure, Kidney Health Evaluation for Adults with Diabetes (KED) into the MA Star Ratings in 2020:

1. Kidney Health Evaluation in Diabetes & Hypertension
2. CKD Diagnosis Among High-Risk Populations
3. Cardiovascular and Kidney Disease Risk Reduction in At-Risk Populations
4. Use of GFR and/or albuminuria to identify individuals with “rapidly progressing” CKD

The proposed measure specifications are included in Appendix I. We acknowledge that these measures are based on data elements unavailable for health plan measure development. Nonetheless, greater alignment around these measure concepts can help ensure that payment and quality incentives consistently reinforce early identification, care coordination, shared decision-making, and progression slowing across CMS programs.

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In summary, the National Kidney Foundation (NKF) expresses our thanks to CMS for their efforts on advancing the affordability of drugs and quality of Medicare Advantage coverage. Still, we believe there is more CMS can do to ensure their efforts meet the needs of every patient. NKF stands ready to work with CMS on implementing these policies in ways that advance affordability, fairness, and high-quality kidney care across the Medicare program.

For any questions or concerns, please contact Carson Smith at the National Kidney Foundation, at Carson.Smith@kidney.org.

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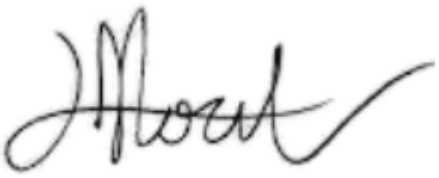
We thank you for your continued leadership and stand ready to assist in advancing this critical public health priority.

Sincerely,



Dr. Jesse Roach, MD
Senior Vice President, Government Relations
The National Kidney Foundation

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Appendix I.

CKD Diagnosis Among High-Risk Populations	MIPS
Element	**Components**
Numerator	Number of people with diabetes and/or hypertension and laboratory evidence of kidney disease (2 values of eGFR >15 ml/min/1.73m^2 but <60 ml/min/1.73m^2 tested greater than 90 days apart and/or 2 uACR >30 mg/g tested greater than 90 days apart) with an appropriate ICD10 for CKD in their health record.
Denominator	• 18-85 years • At least 1 outpatient visit in past 12 months • ICD10 code for diabetes and/or hypertension AND • 2 values of eGFR >15 ml/min/1.73m2 but <60 ml/min/1.73m2 tested greater than 90 days apart AND/OR • 2 uACR >30 mg/g tested greater than 90 days apart
Exclusions	• Diagnosis of AKI • Diagnosis of ESRD • Hospice or palliative care • Pregnancy

Kidney Health Evaluation in Diabetes & Hypertension	MIPS/HEDIS
Element	Components
Numerator	Number of people with diabetes and/or hypertension with evidence of eGFR AND uACR testing during the measurement period.
Denominator	• 18-85 years • At least 1 outpatient visit in past 12 months • ICD10 code for diabetes and/or hypertension
Exclusions	• Diagnosis of AKI • Diagnosis of ESRD • Hospice or palliative care • Pregnancy

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Cardiovascular and Kidney Disease Risk Reduction in At-Risk Populations (MIPS)	
Element	**Components**
Numerator	Prescription SGLT2i, nsMRAs, GLP-1s, or documentation of reason for not prescribing
Denominator	• 18-85 years • At least 1 outpatient visit in past 12 months AND • CKD ICD10 (N1832 or N184) *OR* (CKD w/no DM or HF) • 2 values of eGFR >20 greater than 90 days apart AND • 2 uACR >200 greater than 90 days apart OR (CKD w/DM) • CKD ICD10 or • 2 values of eGFR >20 & < 60 greater than 90 days apart *AND/OR* • 2 uACR >30 greater than 90 days apart AND • DM ICD10 AND/OR • Heart failure ICD10
Exclusions	Diagnosis of AKI (in measurement period?), Diagnosis of ESRD, Hospice or palliative care, Pregnancy

Use of GFR and/or albuminuria to identify individuals with "rapidly progressing" CKD	MIPS
Element	Components
Numerator	• CKD dx with decline of GFR > 5ml/min/yr (calculated using eGFR data from past 24 months) AND • uACR >30
Denominator	• 18-85 years • At least 2 outpatient visit in past 24 months AND • CKD ICD10 (N181- N184) AND • 2 values serum creatinine with eGFR over 24 months
Exclusions	• Diagnosis of AKI during measurement period • Diagnosis of ESRD • Hospice or palliative care • Pregnancy