COALITION FOR KIDNEY HEALTH

Dr. Mehmet Oz
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW.
Washington, D.C. 20201

February 25, 2026

Subject: CY 2027 Medicare Advantage Advance Notice

Dear Dr. Oz,

The Coalition for Kidney Health (C4KH) thanks the Agency for the opportunity to submit comments on the Calendar Year 2027 Medicare Advantage (MA) Advance Notice.

The Coalition for Kidney Health is a multi-stakeholder group of partners committed to public policies that advance early detection and treatment of chronic kidney disease (CKD). CKD, the progressive loss of kidney function over time, is common and burdensome. Overall, more than 1 in 3 Americans is at risk for kidney disease and more than 1 in 7 Americans have kidney disease.1 CKD is more common in people with risk factors such as diabetes, hypertension, heart disease. CKD is closely related to a range of comorbidities, especially to cardiovascular disease, which leads to high morbidity and mortality.[1] In fact, people with CKD are more likely to die of cardiovascular disease than progress to kidney failure.[2] Those who do progress to kidney failure depend on dialysis or a kidney transplant to survive. **Astonishingly, despite the prevalence, clinical implications, and downstream costs associated with kidney disease, most people who have CKD are unaware of their condition.**

As a threshold matter, we offer our sincere thanks to CMS for proposing removal of the constraint applied to HCC 328 Chronic Kidney Disease, Moderate (Stage 3B) and HCC 329 Chronic Kidney Disease, Moderate (Stage 3, Except 3B) that had resulted in equal coefficients for these two distinct stages of CKD. C4KH strongly supports the proposed 2027 CMS-HCC model that would reflect the distinct costs associated with CKD Stages CKD3a and 3b.

The membership of the C4KH is committed to using every tool at our disposal to advance a kidney disease paradigm where prevention, early screening and diagnosis are at the fore. Change is a process in which seemingly minor changes, like updates to the CMS-HCC model, compound over time to transform our healthcare system towards kidney health. We thank CMS for its support in the process of change. Once finalized, the 2027 CMS-HCC model will send a strong signal to health plans and contracting entities about resources needed to manage the earlier stage kidney disease population, with downstream implications for plan designs, risk stratification, value-based care arrangements, therapeutic interventions, and, most importantly, the nation's kidney health.

As Medicare Advantage continues to grow, now covering more than half of all Medicare beneficiaries, the policy decisions reflected in the Advance Notice have increasing significance for individuals living with chronic kidney disease (CKD). The proposed 2027 CMS-HCC model reflects this growing reality, highlighting the opportunity to advance meaningful, creative solutions to manage kidney disease in the

[1] https://usrds-adr.niddk.nih.gov/2023/chronic-kidney-disease/3-morbidity-and-mortality-in-patients-with-ckd
[2] Dalrymple LS, Katz R, Kestenbaum B, Shlipak MG, Sarnak MJ, Stehman-Breen C, Seliger S, Siscovick D, Newman AB, Fried L. Chronic kidney disease and the risk of end-stage renal disease versus death. J Gen Intern Med. 2011 Apr;26(4):379-85. doi: 10.1007/s11606-010-1511-x. Epub 2010 Sep 19. PMID: 20853156; PMCID: PMC3055978.

MA market. We look forward to working with CMS to shape these opportunities and realize the Administration's commitment to transforming the chronic disease landscape in the United States.

On behalf of the 35.5 million people living with kidney disease in the United States, thank you.

Section G. CMS-HCC Risk Adjustment Model

The C4KH strongly supports CMS's proposal to separate CKD Stage 3a and CKD Stage 3b within the risk adjustment model. This refinement reflects a more clinically accurate understanding of kidney disease progression and better aligns payment policy with patient complexity. CKD is not a monolithic condition. Stage 3b patients face substantially higher risks of cardiovascular events, hospitalization, and progression to kidney failure than those with Stage 3a disease. In addition, individuals with more advanced CKD are more likely to experience compounding clinical and social risk factors. Recognizing this distinction in the risk adjustment framework promotes plan designs and value-based contracts that are more precisely calibrated to the opportunities to reduce downstream cardiovascular utilization and mortality when kidney disease is properly screened and diagnosed. The precision of calibration is especially important because over 1.5 million *diagnosed* kidney patients are being managed through value-based contracts, with that figure growing rapidly.[3] Ten value-based care companies manage these patients across all 50 states with a combination delivery models emphasizing different combinations of technology, services for patients, and services for the clinicians and practices that care for them.[4] While the details of MA plan contracts with value-based care companies are not publicly available, we know that the ways contracts are designed implicate care delivery models. The proposed updates to the CMS-HCC model will allow for more precise contract designs that better target the risk that value-based care companies take on to the opportunities to manage that risk on behalf of beneficiaries served by MA.

As CMS continues to refine the MA risk adjustment model, the C4KH encourages ongoing attention to early-stage CKD. Policies that accurately reflect disease burden and promote investment in early kidney care are essential to ensuring beneficiaries receive high-quality, comprehensive, and sustainable coverage.

Section F. RxHCC Risk Adjustment Model

The CK4H understands that the Prescription Drug Hierarchical Condition Category (RxHCC) risk adjustment model is a different predictive model than the CMS-HCC model, based on clusters of conditions that predict Part D drug spend. The problem is that the RxHCC model is another mechanism catalyzing the feedback loop that entrenches the status quo in which kidney disease is not treated until it is an emergency and the opportunities to slow or stop progression and preserve cardiovascular health have been lost. The RxHCC risk adjustment model only accounts for CKD stages 4 and 5 (RXHCC263 and RXHCC262, respectively) and does not set coefficients for either condition. We understand that the model is designed to include flags that trigger cost groupings and that CKD stages 4 and 5 are currently among those triggers. The RxHCC risk adjustment model thus reflects the treatment paradigm in which kidney disease, which is a silent condition, is not screened, diagnosed, and treated until its latest stages.

The pharmacologic landscape for CKD is undergoing a transformation. There has never been a time during which a beneficiary with CKD has as many options to delay the progression of disease and reduce his or her risk of cardiovascular complications. The ability of beneficiaries, society, and the Trust Fund to

[3] https://media.signalsfs.com/p/the-current-landscape-of-value-based-26d
[4] https://media.signalsfs.com/p/the-current-landscape-of-value-based-1d4

benefit from new opportunities in CKD management hinges on the ability of beneficiaries with CKD to access the range of treatments for their condition.

We also note that we continue to learn about the underlying pathophysiology of kidney disease. Although CKD is more common in people with risk factors such as diabetes, hypertension, heart disease, and obesity, as well as in the elderly,[5] CKD can also be caused by inherited conditions like polycystic kidney disease (PKD), glomerular diseases, and autoimmune conditions like systemic lupus erythematosus, among other conditions and circumstances.[6] Not all kidney disease drug spend will cluster together with conditions like diabetes, hypertension, and heart failure. We would be grateful for CMS' perspective on how we might work to incorporate a more nuanced understanding of early kidney disease treatment in the RxHCC risk adjustment model.

Attachment IV. Updates for Part C and D Star Ratings

The C4KH continues to support the adoption of the measure, Kidney Health Evaluation for Patients with Diabetes, in the Medicare Advantage Star Ratings. Kidn

ey Health Evaluation for Patients with Diabetes is a core kidney disease screening measure upon which other health plan measures focused on the diagnosis and management of kidney disease should build. The National Kidney Foundation (NKF) is the measure steward of the measure Kidney Health Evaluation (Quality ID #488). In addition to work to expand the denominator of the measure to incorporate hypertension, NKF has observed that securing guideline concordant screening of kidney disease is not resulting in kidney disease ***diagnosis***. Therefore, NKF is advancing measure development work to advance a measure that would assess kidney disease diagnosis (see Appendix I). NKF has shared these plans with the National Committee for Quality Assurance (NCQA) and would be pleased to discuss health plan measure concepts that would build on the foundation of Kidney Health Evaluation for Patients with Diabetes with CMS.

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The C4KH thanks CMS for its consideration of these comments. Should there be questions or comments on this submission, please contact Miriam Godwin at Miriam.godwin@kidney.org.

Sincerely,
The Coalition for Kidney Health

Appendix I.

Kidney Health Evaluation in Diabetes & Hypertension	MIPS/HEDIS
Element	**Component**
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

[5] https://www.kidney.org/kidney-topics/chronic-kidney-disease-ckd
[6] *Ibid.*

	• ICD10 code for diabetes and/or hypertension
Exclusions	• Diagnosis of AKI • Diagnosis of ESRD • Hospice or palliative care • Pregnancy

CKD Diagnosis Among High-Risk Populations	MIPS
Element	**Component**
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