Office of Assistant Secretary for Health (OASH) Chronic Kidney Disease (CKD)/Cardio-Renal-Metabolic (CRM) Syndrome Policy Options

August 19, 2026

COALITION FOR KIDNEY HEALTH

Background

Historically, there have been few screening and treatment options available for the 37 million Americans with chronic kidney disease (CKD). As many as 9 in 10 CKD patients go undiagnosed -- nearly 40% of end-stage renal disease patients learn of their condition only after it has progressed to kidney failure. Delays in diagnosis after symptom onset and a lack of effective upstream treatment options result in patients needing costly and burdensome care, including dialysis and transplant. In addition, patients with late-stage CKD are at a markedly higher risk of cardiovascular events. [1] Individuals with one condition of CKD, CVD, or T2D account for almost double the average healthcare spending per capita, while the average cost for an individual with all three conditions is approximately four times that of the average American.[2]

In 2019, President Trump issued an Executive Order on Advancing American Kidney Health, directed at increasing home dialysis options and making more organs available for donation. [3] Since this EO was released, the focus of CKD treatment has begun shifting toward earlier intervention and therapies. Advances in screening and diagnostics, along with the emergence of new, effective therapies, now offer the potential to identify CKD earlier and slow its progression.

The federal government has a particular stake in better identifying and treating CKD patients given that, once a patient transitions to end stage renal disease (ESRD), they become eligible for Medicare no matter their age or prior insurance status. Currently, Medicare spends more than $50 billion each year on treatment related to ESRD, including dialysis and transplant.[4] Reducing the progression of kidney disease could save Medicare more than $9 billion.[5] The potential for cost savings is even more significant when considering comorbidities across the cardio-kidney-metabolic (CKM) syndrome, which affect well over 130 million Americans.[6]

The Department of Health & Human Services (HHS) has a multitude of tools at its disposal to create an environment where screening and CKD/CKM management is both encouraged and directly incentivized. A coordinated effort by OASH to raise kidney disease awareness and to promote kidney screening, diagnosis, and early treatment would kick start a whole-of-government approach to moving kidney disease transformation efforts upstream to earlier stages of kidney disease, where they can have the greatest impact on improving Americans health and saving money for the federal government.

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1 Cardiovascular Disease in Chronic Kidney Disease: Pathophysiological Insights and Therapeutic Options - PubMed

2 United States Renal Data System. 2025 *USRDS Annual Data Report: Epidemiology of kidney disease in the United States.* National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2025.

3 Executive Order on Advancing American Kidney Health – The White House

4 National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). May 2023. https://www.niddk.nih.gov/health-information/health-statistics/kidney-disease.

5 Reimagining Kidney Care: From Crisis to Opportunity. American Kidney Fund. https://www.kidneyfund.org/sites/default/files/media/documents/_WEB_AKF_%20Kidney%20Disease%20Impact%20Economic%20White%20Paper_FINAL.pdf?s_src=website&s_subsrc=Policy%20Resources%20%7C%20Download%20the%20white%20paper.

6 Centers for Disease Control and Prevention. *Chronic Kidney Disease in the United States, 2023*.

COALITION FOR KIDNEY HEALTH

Policy Options

I. OASH as Convener Across HHS

A. Kidney Health Policy Roundtable to Align Federal Prevention, Payment, Workforce, and Evidence Efforts

Brief Description: Establish an OASH-led policy roundtable(s) including patient, health professional, and industry perspectives, as well as potentially participants from cross-HHS Operating Divisions (OPDIVs), to identify policy opportunities across HHS agencies. In addition to kidney community stakeholders, this effort could bring together CDC (surveillance and prevention), HRSA (workforce and safety net infrastructure and the transplant system), CMS (payment and delivery system reforms, including ACCESS and ELEVATE models), IHS (direct service delivery), NIDDK (scientific expertise), and AHRQ (evidence generation) to consider patient-centered policy changes and coordinate and align activities. The roundtable(s) would focus on l strategies for CKD prevention, early detection, and management.

Agency: HHS/OASH; CMS; CDC; HRSA; IHS; AHRQ; NIDDK

Statutory/Regulatory Authority: OASH has authority to convene and coordinate cross-agency public health initiatives and to elevate priority health issues across HHS. Participating OPDIVs maintain independent statutory authority across their respective domains (e.g., CMS for payment and delivery system models; CDC for prevention and surveillance; HRSA for workforce and safety net programs; IHS for direct care delivery; AHRQ for evidence generation), which can be aligned through interagency coordination without requiring new legislation.

Timeline: 3-6 months to establish

Political/Practical Feasibility: OASH frequently serves as a convener across HHS and can establish roundtables with external stakeholders as well as interagency participation with minimal administrative burden. This effort would identify opportunities to build on existing programs and authorities within each OPDIV, focusing on improved coordination rather than new program creation.

Impact: Significant if it identifies areas of widely agreed upon need and opportunity, catalyzing/fueling actions by OPDIVs to focus on kidney efforts; limited otherwise. Effectiveness will likely depend on senior/political leadership buy-in.

B. CMS-Aligned Federal Effort to Expand Kidney Disease Screening, Surveillance, and Provider Engagement

Brief Description: Position OASH as a cross-agency convener to amplify and support CMS-led efforts to expand kidney disease screening, early identification, and CKM care improvement, while leveraging CMS infrastructure and joint CMS–OASH initiatives (e.g., provider pledges, public campaigns, and innovation competitions) to drive uptake across providers, health systems, and payers.

Agency: HHS/OASH; CMS

Statutory/Regulatory Authority: CMS has authority to implement quality improvement initiatives, demonstrations, and stakeholder engagement efforts tied to Medicare and Medicaid programs, including provider-focused campaigns and innovation activities (e.g., through the Innovation Center and KidneyX-related efforts). OASH has authority to coordinate cross-agency initiatives, elevate national public health priorities, and support public-private partnerships and campaigns.

Timeline: 1-3 years

Political/Practical Feasibility: High feasibility as this approach builds on existing CMS initiatives and authorities, with OASH serving in a convening and amplification role rather than creating new programs. Joint initiatives (e.g., pledges, prize competitions) align with prior federal and efforts public-private partnerships (e.g., Blue Button pledge, KidneyX) and can be structured as voluntary efforts. Coordination across CMS and OASH will require alignment on priorities but does not require significant new appropriations.

Impact: Significant if OASH roundtables catalyze meaningful actions across other agencies, but OASH's own authority/awareness capabilities are limited.

C. *Tribal Health Partnership to Advance Kidney Disease Prevention and Care in Native Communities*

Brief Description: Engage OASH as a cross-agency convener, and home to the U.S. Public Health Service Commissioned Corps, to partner with the Indian Health Service (IHS) to elevate kidney disease prevention, screening, and care efforts among Native populations—starting with formal inclusion of IHS in federal kidney health roundtables and expanding to amplify and resource existing IHS-led initiatives.

Agency: HHS/OASH, Commissioned Corps; Indian Health Service (IHS); CDC; CMS

Statutory/Regulatory Authority: IHS has authority to deliver direct health services to American Indian and Alaska Native populations and to implement public health and clinical programs within its facilities and tribal partnerships. OASH has authority to coordinate across HHS agencies and elevate priority health issues, including through convenings and public health campaigns, and oversees the Commissioned Corps. CMS and CDC maintain authorities over coverage policies, quality initiatives, and prevention programs that can be aligned with IHS efforts

Timeline: 1-2 years

Political/Practical Feasibility: High feasibility given OASH's convening role and IHS's existing service delivery infrastructure and focus on chronic disease management. Initial engagement (e.g., roundtable participation) requires minimal new resources and builds on existing federal relationships. Additional resourcing or expansion of IHS activities may require further coordination with HHS leadership and appropriators but can be framed as addressing well-documented disparities in kidney disease incidence in Native populations.

Impact: Significant within IHS populations; IHS interventions can sometimes then be models for interventions in other systems, although adapting them in other systems can be difficult.

D. *Real-World Evidence Generation for Kidney Disease Diagnostics and Management*

Brief Description: Leverage AHRQ's comparative effectiveness research (CER) and real-world evidence (RWE) capabilities—potentially in coordination with NIH—to evaluate and advance new approaches to kidney disease screening, diagnosis, and treatment, including novel methods for assessing glomerular filtration rate (GFR) and identifying patients at risk of CKD progression. HHS could also consider a partnership with the VA using the Million Veteran's Program (MVP) data set to examine real world evidence of kidney diagnostic and therapeutic interventions.

Agency: HHS/AHRQ; NIH; VA

Statutory/Regulatory Authority: AHRQ has statutory authority to fund and conduct research on healthcare quality, outcomes, and comparative effectiveness, including through its Evidence-based Practice Centers (EPCs) and other research programs. AHRQ is also authorized to generate and synthesize real-world evidence using clinical and administrative data sources. NIH maintains complementary authority to support basic and translational research, which can be aligned with AHRQ's applied and outcomes-focused research efforts.

Timeline: 1-3 years

Political/Practical Feasibility: AHRQ has existing infrastructure and funding mechanisms to support CER and RWE activities and can prioritize kidney health within its current portfolio. Coordination with NIH can further strengthen the research pipeline from innovation to implementation. The level of interest in using AHRQ at a time when the administration is planning to fold it into other parts of the Office of the Secretary may be limited, however.

Impact: Low to Moderate—AHRQ research can garner significant amounts of attention but much work has already been done to assess and design interventions to improve kidney screening and interventions. If AHRQ projects illustrate significant effects of novel therapeutics, this could be impactful.

E. NIH Translational Research on CRM/Kidney Health Interventions

Brief Description: Work with the relevant NIH institutes and centers (NIDDK, NHLBI, National Institute of Nursing Research (NINR), National Center for Advancing Translational Sciences (NCATS)) to develop and announce grant opportunities for research on testing interventions to improve kidney/CKM health (e.g., population-wide screening for CKD in a particular patient population) as well as other federal research funders, such as the Department of Veterans Affairs (VHA Kidney Medicine Program) and federally funded partners, such as the Patient-Centered Outcomes Research Institute (PCORI). Consider leveraging the *Transforming Kidney Health Research* report, developed by the American Society of Nephrology in partnership with the American Association of Kidney Patients, American Kidney Fund, American Society of Pediatric Nephrology, and the National Kidney Foundation. The report emphasizes research on improved screening, diagnostics, and earlier interventions, and already has wide community and bi-partisan Congressional support.

Agency: HHS/NIH/VA

Statutory/Regulatory Authority: While Congressional funding is generally allocated to particular institutes and centers, leadership of the ICs and the Office of the Director generally still have significant amounts of authority to determine the specific priorities for grant-making.

Timeline: 2-3 years for awarding of grants; 5+ years for publishing of research

Political/Practical Feasibility: NIH has administrative flexibility to prioritize certain areas of research and has often done so in the past, and under the new Trump Administration, NIH Director Jay Bhattacharya has indicated an even greater desire to centralize NIH decision-making to serve particular priorities, although the capacity to focus research on new priorities may be limited. Congress has already taken notice of particular efforts to steer funding in specific directions, as outlined in the *Transforming Kidney Health Research* report, and seems supportive of kidney health as an intended and increased priority. (Admiral Christine's team mentioned the possibility of involving NIDDK in OASH roundtables and knew the head of NIDDK, having previously done external affairs/comms at NIH.)

Impact: Long-term but potentially significant—funding research to provide evidence for kidney/CRM interventions could have long-term effects on practice patterns, but would require both the conducting of such research and its publication, and even very rapid NIH efforts take years from awarding of grants to publication of results.

F. OASH–ASPE Cross-Agency Kidney Health Outcomes Report

Brief Description:
Direct OASH, in partnership with the Office of the Assistant Secretary for Planning and Evaluation (ASPE), to develop and publish a recurring cross-agency Kidney Health Outcomes Report that tracks federal progress on improving kidney disease detection, treatment, and outcomes. Unlike Healthy People 2030, which establishes broad public health objectives, this report would serve as an operational federal accountability framework, integrating data and activities across HHS agencies and identifying measurable opportunities to reduce undiagnosed chronic kidney disease (CKD), slow disease progression, improve management of cardio-kidney-metabolic (CKM) conditions, and reduce avoidable spending associated with kidney failure. The report could establish a common set of federal kidney health indicators and provide annual or biennial assessments of agency activities, program performance, and outcome trends.

Agency:
HHS/OASH; ASPE; CMS; CDC; NIH/NIDDK; HRSA; IHS; AHRQ

Statutory/Regulatory Authority:
OASH has authority to coordinate cross-department public health initiatives and elevate priority health issues across HHS. ASPE has responsibility for policy analysis, program evaluation, and data-driven assessment of HHS programs and outcomes. The report could be developed using existing agency data, evaluation authorities, and interagency coordination mechanisms without requiring new statutory authority.

Timeline:
6–12 months for initial report; annual or biennial updates thereafter.

Political/Practical Feasibility:
High. The initiative relies primarily on coordination, analytics, and reporting functions already housed within HHS. Because it does not require new payment policies, regulations, or appropriations, it could be launched administratively. The effort would also align with Administration priorities around transparency, accountability, chronic disease prevention, and government efficiency by identifying areas where earlier intervention may improve outcomes and reduce downstream federal expenditures.

Potential Metrics/Focus Areas:

- Rates of CKD screening and diagnosis.
- Proportion of CKD patients identified before progression to advanced disease.
- Rates of kidney-protective therapies among eligible populations.
- CKM-related hospitalization and cardiovascular event trends.
- ESRD incidence and progression rates.
- Medicare and Medicaid spending associated with CKD and ESRD.
- Outcomes among high-risk populations, including rural, Tribal, and underserved communities.
- Agency-specific initiatives and performance indicators related to kidney disease prevention and management.

Impact:
Potentially significant. A cross-agency outcomes report would create a durable federal focus on kidney disease that extends beyond awareness campaigns and individual agency initiatives. By establishing shared metrics and publicly tracking progress, the report could improve coordination among HHS agencies, identify policy gaps, support future executive and legislative initiatives,

and elevate kidney disease as a measurable federal health priority. It would also provide a mechanism for evaluating whether existing federal investments are producing improvements in early detection, treatment uptake, disease progression, and healthcare costs.

II. OASH-Specific Policy

A. National Kidney Health Awareness/Education Campaign with Provider and Industry Participation

Brief Description: Establish a coordinated public-private kidney health awareness campaign, building on existing initiatives (e.g., Boehringer Ingelheim's "Detect the SOS" campaign, the National Kidney Foundation's "Are You the 33%?" campaign, and the American Society of Nephrology's "United 4 Kidney Health" campaign), in which private stakeholders enter into voluntary Memoranda of Understanding (MOUs) with HHS to align messaging and expand efforts to promote CKD awareness, screening, and early intervention. OASH, for its part, can create a new website (e.g., Kidney.gov) to consolidate and amplify the private-sector messages.

Agency: OASH

Statutory/Regulatory Authority: HHS has authority to enter into voluntary MOUs and public-private partnerships to advance public health priorities. CDC can support population-level awareness and prevention messaging, while CMS can reinforce provider and beneficiary engagement through outreach and education tied to Medicare and Medicaid populations.

Timeline: 6 months-1 year to launch

Political/Practical Feasibility: Leverages existing private sector investments and infrastructure without requiring new statutory authority or significant federal funding. Voluntary participation allows flexibility for stakeholders to align with campaign goals while maintaining independence. Coordination across diverse partners may require a neutral organizing structure within HHS.

Impact: Potentially significant (the impact of public awareness campaigns has ranged from very significant to almost nothing—e.g., some campaigns have been shown by HHS to have significant effects, like the Tips for Smokers campaign, while others have not).

B. Improve Medical School/GME Training on Kidney Education

Brief Description: Work with the Department of Education (Ed) to announce an initiative urging medical schools and/or residency programs to include kidney health education in the program of voluntary commitments from a medical school to increase nutritional education. Consider exploring other avenues to increase the presence or effectiveness of kidney health education in UME and GME in partnership with kidney community stakeholders.

Agency: HHS, Ed

Statutory/Regulatory Authority: HHS has also already secured voluntary commitments from a several medical schools to increase nutritional education (announced in early June 2026).

HHS also exercises indirect authority over the design of residency programs, because most residency slots are funded either through Medicare-funded Graduate Medical Education or other avenues (e.g., Teaching Health Centers residencies), and, generally speaking, federal funding is only provided to residencies accredited by private accreditors, which are selected/approved by HHS. Similarly, Ed has indirect authority over the design of medical school curricula because federal graduate student loan eligibility is contingent on accreditation of a given medical school.

Timeline: Approx. 1 year for implementation; much longer for impact.

Political/Practical Feasibility: The Administration has already. CKD/CRM education would be complementary of these efforts.

Impact: Potentially very significant if it raises awareness among providers, but fairly long-term (5+ years minimum) to have an effect. Also unclear to what extent underemphasis on kidney health in medical schools is an issue.

C. "Kidney Commitment" Pledge

Brief Description: Develop a pledge for providers or employers/plans to improve rates of screening, diagnosis, and treatment for CKD or CRM. Such a pledge could take various forms:

- **Health systems:** Providers could pledge to align their practice patterns with various standards that would increase the rates of screening/diagnosis/treatment for CKD or CRM issues, such as NKF's CKD Intercept Model, updated guidelines on kidney care, or to increase awareness among their patients about the potential for interventions to delay CKD progression.
- **Plans/Employers**: Commercial payers, such as employers and health insurance plans, could pledge to align their coverage policies with new guidelines regarding kidney health interventions, or to increase rates of screening or diagnosis for CKD in their covered populations (e.g., reduce the rate of undiagnosed CKD by X percent over some period of time).

This pledge could also come alongside an effort by the federal government to set goals around the reduction of undiagnosed CKD or reductions in progression to ESRD, similar to the first Trump Administration's setting goals to increase the number of kidney transplants.

Agency: HHS

Statutory/Regulatory Authority: Such "pledges" do not rely on a particular legal authority, although various other policy levers described in this memo may support or facilitate providers, plans, and employers implementing this pledge.

Timeline: 1 year

Political/Practical Feasibility: The Administration has shown significant interest in using these types of "pledges" to advance policy goals without imposing new mandates on the private sector or in areas where regulatory authorities may be limited.[7] Uptake by outside parties may vary: Employers/plans would arguably be encouraged to participate in order to improve health in their populations (although there would be certain costs involved in fulfilling such commitments), as well as to garner goodwill with the Administration.

Impact: Potentially significant—can impact patients in the commercial market. However, such pledges often are relatively closely aligned with policies that the parties may be planning to take anyway, so the added value of a coordinated pledge is not always significant or may be difficult to determine, although system-wide adoption of CKD Intercept may have more impact.

D. Award Prizes for Development of New Screening/Diagnostic Tools or Data Efforts

Brief Description: Develop a prize competition, under the auspices of KidneyX, to support new technological solutions to promote CKD screening/diagnosis. Such concepts could include:

- New approaches to use existing CMS or other government/private sector data to identify patients at risk of CKD progression or adverse CKM outcomes.
- New tools for providers or patients to assess individual patients' risk of CKD progression or adverse CKM outcomes.

[7] https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html (prior authorization reform); https://www.cms.gov/newsroom/press-releases/white-house-tech-leaders-commit-create-patient-centric-healthcare-ecosystem (EHR interoperability).

Agency: HHS

Statutory/Regulatory Authority: HHS and its agencies have authority under the COMPETES Act to conduct prize competitions, and ASN and HHS established KidneyX as a dedicated mechanism to use this authority in the kidney space, including securing $5 million in annual appropriations (which can also be combined with private-sector funding). HHS has in the past also used general operations funds or CMMI appropriations to fund such prizes.

Timeline: 1 year for developing competition, 2 years for running it.

Political/Practical Feasibility: HHS has used prize authorities in the past to promote innovation in kidney health, KidneyX's mission explicitly includes "prevention and diagnosis," and the ASN team has expressed strong interest in partnering with others in the community conceptualize a KidneyX prize around CKD screening/diagnosis. Admiral Christine expressed interest in using KidneyX to advance kidney health.

HHS has also commonly used this authority, as well as acting as a general convener, for efforts to improve analysis of existing data sets. This initiative would align closely with the Administration's interest in engaging with private-sector innovators and advancements in technology.

Impact: Potentially significant. Depending on how the prize competition is structured and funded, and what solutions are desired, it could potentially elicit the development or surfacing of technologies that are ready or near ready for widespread adoption to improve CKD screening/diagnosis. It could also contribute to increased awareness and interest from stakeholders as part of a broader strategy.

E. Grant Program for Patient Navigators

Brief Description: Create a grant program to provide grants to patient groups, public health organizations, or other partners to support efforts to increase CKD screening and diagnosis rates, connect patients to treatment, navigate insurance coverage issues, and support adherence.

Statutory/Regulatory Authority: Can be done administratively, as long as funding is available (which is generally annually appropriated for existing grant authorities), because HHS offices have existing grant authority for such grants (see, e.g., 42 U.S.C. § 300u-6 (Section 1707 of the Public Health Service Act)).

Timeline: 1-2 years

Political/Practical Feasibility: Practically simple, as HHS launches new grant programs of this type in line with Administration priorities regularly (see, e.g., a 2016-2017 effort to support lupus patients), although status of current appropriations is unclear and more extensive review of grants-making may slow policymaking under this administration.

Impact: Limited in scope but would improve diagnosis and access to treatment among individuals served by grantees. Could also provide a model for future CMMI or commercial payer efforts.