American Society of Nephrology

Dorothy Fink, MD
Acting Secretary
Department of Health and Human Services
200 Independence
Washington, DC 20201

**Re: CMS-4208-P: Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly**

Dear Dr. Fink:

On behalf of the more than 37,000,000 Americans living with kidney disease 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 respond to the proposed Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly.

ASN has supported efforts to expand MA since the 21st Century Cures Act which allowed individuals already diagnosed with kidney failure, i.e., end-stage renal disease (ESRD), to join these plans. This has led to 50 percent of Medicare-eligible individuals with kidney failure being enrolled in MA, including a 72 percent relative increase in MA enrollment (from 25 percent to 43 percent of Medicare enrollees with kidney failure) in the first two years after the Act's implementation.[1] As those numbers continue to rapidly climb, ASN urges the Centers for Medicare and Medicaid Services (CMS) to monitor existing patient guardrails for potential challenges and opportunities for improvement.

1. **ASN strongly supports the proposals requiring Medicare Advantage Organizations (MAOs) to report additional data related to the use of prior authorization.** To understand the impact of the use of prior authorization on MA enrollees' access to medical services, including dialysis and other kidney health efforts, nephrology and other specialty services related to managing chronic kidney disease (CKD), and transplant services, we urge CMS to collect the data points outlined in the proposed rule, which are:

- The percentage of standard prior authorization requests that were approved, reported by each covered item and service.

[1] Nguyen, K. H., Oh, E. G., Meyers, D. J., Rivera-Hernandez, M., Kim, D., Mehrotra, R., & Trivedi, A. N. (2024). Medicare Advantage enrollment following the 21st Century Cures Act in adults with end-stage renal disease. JAMA Network Open, 7(9), e2432772-e2432772.

- The percentage of standard prior authorization requests that were denied, reported by each covered item and service.

- The percentage of standard prior authorization requests that were approved after appeal, reported by each covered item and service.

In addition, in order to provide needed transparency into the efficiency and timeliness of appeal processes where prior authorization requests may have been improper, ASN also urges CMS to require the collection of another related data point: the average and median time that elapsed between the submission of an appeal and a decision by the MA plan.

- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, reported by each covered item and service.

- The percentage of expedited prior authorization requests that were approved, reported by each covered item and service.

- The percentage of expedited prior authorization requests that were denied, reported by each covered item and service.

- The average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard prior authorizations, reported by each covered item and service.

- The average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations, reported by each covered item and service.

ASN strongly supports reporting these data elements by each covered item or service rather than using an aggregate approach to establish transparency and empower patients and their care partners to make informed health care decisions. It is important to understand the impact of prior authorization in the ability to access CKD services, dialysis, and kidney transplantation. In addition, we urge CMS to clarify that these data elements should be reported for initial prior authorizations, as well as re-authorization requests.

Some MA plans require the re-authorization of dialysis services as often as every three months. These prior authorizations can apply to the dialysis treatment itself, to medications, and to referrals to dialysis related providers, according to ASN members. Frequent re-authorizations for a chronic life-saving therapy such as dialysis are burdensome and could lead to harmful delays in care.

2. **ASN is concerned about network adequacy in MA.** There are reports of inadequate networks of both dialysis and transplant centers. For example, in 2020, MA contracts' networks included an average of 51 percent of dialysis

facilities in their service areas; 23 percent of contracts had “narrow networks” and included at most 25 percent of available dialysis facilities in network.[2]

ASN urges CMS to track and report information on individuals switching from MA to traditional Medicare with some amount of detail on the reason for the switch. This information could improve analysis of where the gaps are between coverage and patient expectations.

3. **ASN strongly supports the proposed changes to the provider directories** to streamline the individual’s care-seeking experience and improve their access to the information they need to make informed health care choices.

We believe that making MA provider directories part of Medicare Plan Finder (MPF) for the 2026 Annual Enrollment Period (AEP) and policies ensures the accuracy of the data being submitted through MAO attestations and supports a patient-centered approach to addressing the challenges many individuals with kidney disease or kidney failure have experienced.

4. **ASN has concerns regarding perceived gaps in quality reporting for individuals undergoing dialysis.** Compared with those in traditional Medicare, ESRD patients in MA are more likely to receive dialysis at the two largest for-profit dialysis chains, travel further for care, and receive care at lower quality facilities.[3] In the Proposed Rule, CMS sets forth a series of modifications to the quality metrics used under the MA quality and Five Star programs.

Given the explosion of individuals entering MA requiring dialysis care, ASN urges CMS to work with ASN to identify a subset of measures or ways to stratify existing MA measures to provide greater transparency as to plan performance with regard to CKD and ESRD patients. This approach would address gaps in quality data specific to the management of chronic diseases, support transparency, and empower patient-centered decision-making.

5. **ASN urges CMS to address the problem of some MA plans not recognizing the transitional payment for new drugs, biologicals, and devices that are an integral part of traditional Medicare’s effort to support innovation in the treatment of kidney failure.**

There has been little innovation in the treatment options available for individuals with kidney failure during the last 30 years. Studies have shown that the current flat-reimbursement rate disincentivizes the adoption of innovative treatment therapies. The adoption of the Transitional Drug Add-On Payment Adjustment (TDAPA) and the

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[2] Oh EG, Meyers DJ, Nguyen KH, Trivedi AN. Narrow Dialysis Networks In Medicare Advantage: Exposure By Race, Ethnicity, And Dual Eligibility: Study examines dialysis networks in Medicare Advantage across race, ethnicity, and dual eligibility. Health Affairs. 2023 Feb 1;42(2):252-60.

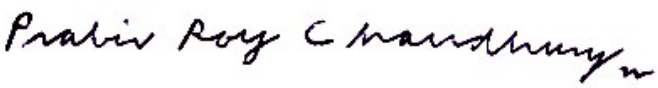
[3] Marr J, Akosa Antwi Y, Polsky D. Medicare advantage and dialysis facility choice. Health services research. 2023 Oct;58(5):1035-44.

Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) is a small, but important step toward addressing the barriers to patient access created by the current payment system.

While some MA plans recognize the TDAPA and TNPIES adjustments and include them in their payments to dialysis facilities, others do not despite the fact that CMS has included payments for these add-ons in the benchmark and rate setting processes. Consistent with the statutory requirement that individuals enrolled in MA plans have access to the same items and services available under traditional Medicare, CMS should ensure that dialysis facilities are reimbursed consistent with the TDAPA and TPNIES add-on amounts available under traditional Medicare.

ASN looks forwards to working with CMS and the Trump Administration to support individuals with kidney diseases or failure as the navigate coverage in either MA or traditional Medicare. If you wish to discuss any of the comments in this letter, please contact David White, ASN Senior Regulatory and Quality Officer, at dwhite@asn-online.org.

Sincerely,



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President