



February 23, 2026

Mr. Daniel Brillman  
Deputy Administrator  
Centers for Medicare and Medicaid Services  
Director, Center for Medicaid and CHIP Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Deputy Administrator Brillman:

On behalf of Kidney Care Partners (KCP), I am writing with respect to several Medicaid provisions included in H.R.1, the Working Families Tax Plan (WFTP) Act [P.L. 119-21]. KCP is an alliance of kidney care community members that includes patient advocates, dialysis care professionals, providers, and manufacturers dedicated to advancing policies that improve the quality of care for Americans diagnosed with kidney disease.

As you know, individuals diagnosed with end-stage renal disease (ESRD) regardless of age can obtain Medicare entitlement if they have the necessary work quarters to meet Social Security's insured-status requirement. Those who receive a favorable determination on their Medicare application generally must wait three months before Medicare benefits begin. No similar Medicare eligibility pathway exists based on an acute kidney injury (AKI) diagnosis. For the small segment of ESRD patients not eligible for Medicare, are in the Medicare waiting period, have applied for Medicaid coverage under another pathway, or in the case of an individual with AKI, have no other options, the Medicaid expansion offers primary coverage for the life-saving care they need.

We appreciate that CMCS released the Information Bulletin to level-set stakeholders' understanding of the state requirements under the law's community engagement provisions.<sup>1</sup> As the regulatory and guidance development process continues, KCP urges CMCS to consider the unique circumstances of Medicaid beneficiaries living with ESRD or AKI. Below we present a series of recommendations to ensure that the law's policies do not inadvertently and inappropriately curtail Medicaid coverage for these medically vulnerable beneficiaries.

### **Explicitly Exempt Medicaid Beneficiaries with ESRD or AKI from the Community Engagement Requirements**

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<sup>1</sup> State Requirements to Establish Medicaid Community Engagement Requirements, CMCS Informational Bulletin, December 8, 2025.



KCP appreciates that the WFTC Act recognizes compliance with the community engagement requirements could prove difficult, if not impossible, for Medicaid beneficiaries who are medically frail or have a “serious or complex medical condition.” Given the nature of their illness and treatment, individuals with ESRD or AKI most certainly meet this standard.

Patients with ESRD or AKI must dialyze multiple times each week with treatment sessions lasting up to four hours. They must see multiple providers and take several medications to maintain their health and for those with AKI, to regain kidney function. In short, the physical and emotional strain of their illness preclude them from meeting the community engagement requirement, and the hardship exemption process, if a state adopts one, would present an additional and unnecessary burden.

Establishing an explicit exemption aligns with the fact that Medicaid eligibility pathways often shift for individuals with ESRD and that many of them would, but for application adjudication timelines, qualify for Medicaid through other avenues. For example, the Social Security Administration’s (SSA) disability standards assume that individuals with ESRD or those awaiting a transplant meet Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) eligibility rules. However, the SSA must confirm eligibility through medical and administrative reviews, which can take six to eight months. In the interim, some individuals may receive temporary Medicaid coverage under the expansion, which is a completely legitimate pathway. Other Medicaid beneficiaries enrolled through the expansion may eventually qualify for Medicaid through mechanisms, such the spend-down or medically needy programs.

Deeming individuals with ESRD or AKI as meeting the community engagement requirements will ensure administrative issues do not cause care disruptions that could jeopardize their health and life and lead to costly, yet avoidable complications. Importantly, several longstanding federal precedents reflect Congress and the Centers for Medicare & Medicaid Services’ (CMS) view that ESRD and AKI are serious and complex conditions. First, more than 50 years ago, Congress recognized the extraordinary needs of individuals with ESRD by extending Medicare eligibility to them based on their diagnosis. In addition to the SSI and SSDI policies mentioned above, CMS designated CKD and ESRD as a “severe or disabling chronic condition” under the Medicare Advantage Chronic Condition Special Needs Plan (MA C-SNP) Program. Beginning in 2017, Congress extended Medicare coverage for outpatient dialysis for beneficiaries with AKI.

### **Apply Guardrails to the More Frequent Redetermination Process to Ensure that Medicaid Beneficiaries with ESRD or AKI Do Not Face Care Disruptions**

Like community engagement requirements, more frequent redeterminations can prove challenging for beneficiaries living with ESRD or AKI. In addition to the treatment time, individuals with these conditions often experience after-care complications, including fatigue,



nausea, and headaches, among others. Many Medicaid beneficiaries also face other non-clinical circumstances, such as lack of transportation and housing insecurity, which can undermine their ability to navigate more frequent redeterminations.

To be clear, KCP agrees that redeterminations are imperative to protecting Medicaid's integrity. However, we believe the prior law framework that required a redetermination no more frequently than every 12 months balanced that objective while minimizing burden for beneficiaries with a serious or complex medical condition. Ideally, KCP supports exempting Medicaid beneficiaries with ESRD or AKI from the WFTC Act's more frequent redetermination requirements. At a minimum, we strongly encourage CMCS to ensure that states adopt guardrails, including: (1) using claims or other administrative data to identify Medicaid beneficiaries with ESRD or AKI; (2) provide additional, perhaps earlier, notices regarding an upcoming redetermination; and (3) granting additional time and other needed support when a Medicaid beneficiary experiences a health or other crisis, such as a hospitalizations, that impedes their ability to comply.

#### **Limit Cost-Sharing Amounts for Life-Saving Care Delivered to Medicaid Beneficiaries with ESRD or AKI**

The WFTC Act requires states to impose cost-sharing of up to \$35 per service for Medicaid beneficiaries with incomes between 100% and 138% of the federal poverty level covered through the expansion with the goal of increasing cost-sensitivity and curb over-utilization. Although the law excludes some services and care delivered at certain facilities from the new cost-sharing requirements, KCP is deeply concerned that it does not contemplate the impact they will have on beneficiaries receiving frequent and recurring care, like dialysis. This treatment is not elective and certainly not at risk for over-utilization.

Assuming the maximum of \$35, a Medicaid beneficiary receiving dialysis would incur \$455 in cost-sharing each month. We appreciate that the beneficiary will reach the five-percent cap on out-pocket costs relative to income within a few months. However, dialysis represents just one component of their care; these patients must see their nephrologists, other specialists, and fill multiple prescriptions – all of which are subject to cost-sharing. For an individual with ESRD or AKI, maintaining employment can be extremely difficult if not impossible. The WFTC Act policy will add an untenable financial strain that will likely cause patients to forego necessary care, resulting in significant health deteriorations, preventable hospitalizations and deaths.

Although as noted above, the law establishes service and facility exclusions, it does not preclude CMS from applying other existing beneficiary protection authorities to define additional exempted services, such as dialysis. Nor does the law prevent CMCS from directing states to de minimus cost-sharing for other services frequently utilized by individuals with



serious and complex medical conditions, such as ESRD or AKI. KCP believes such actions squarely align with CMS' overall directive and discretion to implement policies aimed at achieving Medicaid's fundamental goal of ensuring access to necessary care.

**Consider Interactions Between the Medicare Waiting Period and Limitations on Retroactive Coverage**

The WFTC Act limits retroactive Medicaid coverage to one month for beneficiaries covered through the expansion and two months for all other eligibility pathways. As explained earlier in this letter, Medicare entitlement generally begins three months after the SSA makes a favorable eligibility determination. If an individual does not immediately apply for Medicaid coverage, this policy could leave them – and providers – exposed to significant costs incurred during this coverage gap. In addition, some individuals may not immediately apply for Medicaid due to a prolonged period of medical incapacitation. In these cases, limiting retroactive Medicaid coverage would have the same negative effect on patients and the providers caring for them. To prevent these outcomes, KCP recommends that CMS: (1) include language in regulation and guidance to include treatment for ESRD and AKI, all forms of dialysis, kidney transplantation, and all related diagnoses as “qualified medical expenses” that will trigger eligibility for retroactive enrollment; (2) provide for expedited or presumptive retroactive eligibility when medical incapacitation delays an application for coverage; and (3) apply to other current beneficiary protection authority to afford a three-month retroactive coverage to beneficiaries with a serious or complex medical condition.

KCP is grateful for the opportunity to submit our views on these important policy matters. We would welcome the opportunity to discuss these issues with you and your staff in more detail. If Please contact KCP Executive Director Colin Roskey (202-250-1095) if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "LaVarne A. Burton".

LaVarne Burton  
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### **Appendix: KCP Members**

Akebia Therapeutics, Inc.  
American Kidney Fund, Inc.  
American Nephrology Nurses Association  
American Society of Nephrology  
American Society of Pediatric Nephrology  
AstraZeneca  
Atlantic Dialysis Management Services, LLC  
CorMedix, Inc.  
CSL Vifor  
DaVita, Inc.  
Diality, Inc.  
Dialysis Care Center  
Dialysis Patient Citizens, Inc.  
Fresenius Medical Care North America  
Greenfield Health Systems, Inc.  
Kidney Care Council  
North American Transplant Coordinators Organization  
Novartis  
Nephrology Nursing Certification Commission  
Pathalys Pharma, Inc.  
Renal Healthcare Association  
Renal Physicians Association  
Renal Support Network  
The Rogosin Institute  
U.S. Renal Care, Inc.  
Unicycive Therapeutics, Inc.