



September 9, 2026

Abe Sutton

Director of the Center for Medicare and Medicaid Innovation
Deputy Administrator for the Centers for Medicare and Medicaid Services
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Tom Duvall

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RE: Comments on Leveraging Components of the Long-term Enhanced ACO Design (LEAD) Model for Future Kidney-Specific CMMI Models

Dear Directors Sutton and Duvall,

On behalf of the more than 37,000,000 Americans living with kidney diseases and the nearly 22,000 nephrologists, scientists, and other kidney health care professionals who are members of the American Society of Nephrology (ASN), representing nearly 90% of U.S. nephrologists, thank you for your leadership on, and commitment to, kidney health.

ASN appreciates the Center for Medicare and Medicaid Innovation (CMMI)'s dedication to improving kidney care for Medicare beneficiaries through the development of kidney care-centered value-based care models and applauds the successes of the End-Stage Renal Disease (ESRD) Seamless Care Organizations (ESCO) model and the Comprehensive Kidney Care Contracting (CKCC) model. ASN is writing to provide input on the potential development by CMMI of a next-generation payment model for Medicare beneficiaries with kidney disease, specifically exploring which elements of the Long-term Enhanced ACO Design (LEAD) Payment Model may be adaptable in a new kidney payment model. Additionally, ASN offers recommendations on how CMMI could refine the CMS-Administered Risk Arrangements (CARA) Framework within LEAD to improve kidney care and facilitate direct nephrology participation in value-based care models.

Key policy recommendations in this letter include:

- **Support nephrology-driven value-based kidney care.** ASN encourages CMMI to consider approaches that preserve and strengthen a meaningful, nephrology-driven role in value-based care, including leveraging LEAD as a chassis for a future kidney-specific model and/or adapting CARA to facilitate nephrology

participation within LEAD. Regardless of the approach, future models should preserve specialized accountability for complex kidney populations and provide flexible participation options, predictable financial methodologies, prospective resources, and appropriate protections for nephrology practices.

- **Ensure benchmarking stability and financial predictability:** ASN supports LEAD's permanent baseline benchmarking methodology and stresses that lessons from the KCC Model demonstrate the importance of stable, transparent benchmarks that reflect kidney-specific spending patterns. ASN cautions against trend adjustments that penalize participants for trends outside their control and urges CMMI to base benchmark trends on kidney-specific spending growth in addition to general Medicare trends.
- **Support prospective cash flow:** ASN encourages CMMI to incorporate prospective payment mechanisms that provide predictable resources for upfront investments in care coordination, multidisciplinary teams, and infrastructure transformation.
- **Strengthen data integration and enhance interoperability:** ASN urges CMMI to eliminate data lags experienced in the CKCC Model by providing timely, actionable financial and clinical data and promoting interoperable data exchange across care settings.
- **Prioritize meaningful kidney-specific quality measures.** ASN encourages CMMI to prioritize measures that capture the outcomes and care processes most important to patients with kidney disease, including Optimal ESRD Starts, home dialysis, (chronic kidney disease) CKD progression, evidence-based therapies, Kidney Disease Education (KDE), and preemptive transplantation.
- **Ensure model accessibility for smaller practices.** ASN encourages CMMI to lower barriers for small, independent, and rural practices through flexible risk progression pathways, prospective aggregation options, and tailored volume thresholds.
- **Adapt CARA to the unique needs of nephrology if used within LEAD.** ASN recommends that CMMI tailor CARA through kidney-specific attribution and risk adjustment, predictable benchmarking, flexible risk arrangements, appropriate stop-loss protections, timely data sharing, and participation pathways that accommodate smaller and independent practices.

Leveraging LEAD as a Chassis for a Next-Generation Kidney Payment Model

1. Participation Tracks and Risk Exposure

ASN strongly supports leveraging LEAD's multi-track participation framework as the foundation for a future kidney-specific model. Offering options with varying degrees of risk exposure allows diverse practice types—including independent nephrology

practices, academic medical centers, and various-sized health systems—to participate at an entry point aligned with their financial and operational readiness.

In addition to allowing participants to select among varying degrees of risk exposure, ASN recommends that CMMI include a pathway that begins with at least one full performance year without downside risk before transitioning participants to increasing levels of financial accountability. Successful participation in value-based care models often requires practices to invest in care management infrastructure, multidisciplinary teams, data analytics, and new clinical workflows. A phased approach would give participants, particularly those new to value-based care, sufficient time to develop these capabilities while gaining familiarity with benchmark methodology, beneficiary attribution, and quality measurement before assuming downside financial risk.

2. Benchmarking Methodology

ASN supports the permanent baseline benchmarking methodology used in LEAD and believes it represents an important advancement over the benchmarking approaches used in previous CMMI payment models. Establishing clear and accurate benchmarking provides participants with greater financial predictability and enables practices to make long-term investments in care management infrastructure, multidisciplinary care teams, health information technology, and other resources necessary to improve outcomes for beneficiaries with advanced CKD and ESRD. The use of a permanent baseline for benchmarking also better preserves the value of sustained performance improvements by allowing participants to retain the benefits of efficiencies achieved over time, rather than continually resetting benchmarks based on historical performance. ASN therefore encourages CMS to carry this signature feature of LEAD forward into a future kidney-specific model.

ASN also recognizes CMS's efforts to incorporate a prospective trend component through the Accountable Care Prospective Trend (ACPT) while establishing guardrails to limit divergence from realized Medicare spending. While ASN has concerns about the use of a prospective trend component, we recognize the potential need for some form of trend adjustment to account for changes in Medicare spending over time. ASN stresses that any such mechanism should be leveraged primarily to adjust for unanticipated increases in market trend, be minimally punitive, and designed to avoid overcorrecting based on spending trends outside participants' control. ASN believes predictable financial targets are critical for kidney value-based care participants, given their varied ability to manage downside risk.

While ASN is generally supportive of LEAD's benchmarking methodology, lessons learned from the KCC model demonstrate the importance of ensuring that benchmark updates remain stable, transparent, and reflective of the unique spending patterns associated with kidney disease. Accordingly, if CMMI adopts a similar benchmarking methodology in a future kidney-specific model, ASN recommends several refinements.

- CMMI should ensure that benchmark updates remain prospective and reflect national and regional cost trend growth.** In the CKCC Model, the Retroactive Trend Adjustment (RTA) substantially reduced participant benchmarks by applying a retrospective adjustment based on historical utilization patterns that did not accurately reflect post-pandemic Medicare spending. As ASN noted previously, benchmark adjustments that are not grounded in actual market trends undermine participants' ability to evaluate financial performance, discourage investment in care transformation, and diminish confidence in value-based payment models. CMS should preserve the prospective nature of the permanent baseline methodology and avoid implementing retrospective trend adjustments in future kidney models (except where needed to adjust if the modeling underappreciated actual cost trend). Future kidney models should include guardrails to limit divergence from realized Medicare spending while preserving the prospective nature of the permanent baseline methodology.
- CMMI should use benchmark trends based on kidney-specific expenditure growth rather than general Medicare spending.** Beneficiaries with CKD and ESRD experience utilization patterns that differ substantially from the broader Medicare population due to disease progression, dialysis initiation, transplantation, and frequent high-cost acute events, particularly ER visits and hospitalizations. Benchmark trend factors should adequately reflect these unique expenditure patterns to ensure participants are evaluated against appropriate expectations.
- ASN encourages CMMI to continue emphasizing transparency in benchmark calculations and timely financial reporting.** Participants should receive regular information regarding benchmark development, expenditure trends, and financial performance throughout the performance year. Greater transparency will allow participants to better understand benchmark changes, identify emerging financial risks, and make operational adjustments that improve care delivery while supporting model success. The lack of real-time data in benchmarking in the CKCC model prevents participants from pivoting to focus on high-cost areas until it is much too late to make an impact, impeding the model's ability to show success, participants' ability to improve care, and patients' chances of benefitting relative to FFS care.
- Risk adjustment should similarly account for the clinical complexity and resource needs of individuals with kidney disease.** While the ESRD CMS-HCC Risk Adjustment Model appropriately accounts for the unique clinical needs of populations with kidney failure, given the unique complexity of this patient population, CMMI should evaluate whether the current 3 percent ESRD and 6 percent CKD risk adjustment caps appropriately reflect variation in resource

utilization and care needs across diverse patient populations and should consider whether greater flexibility is warranted.

3. Data Exchange and Cross Setting Care Coordination

Kidney care frequently spans multiple settings, including dialysis facilities, acute care hospitals, skilled nursing facilities, transplant centers, and other specialty providers. This fragmentation creates significant challenges for coordinating care and ensuring clinician participants have timely access to the information needed to manage beneficiaries effectively. These challenges are particularly consequential for patients with advanced CKD and ESRD, who often experience frequent transitions across care settings and require coordination among multiple providers. The U.S. Department of Health and Human Services has recently highlighted these uniquely challenging dynamics in kidney care through the [Kidney Data Discovery Workshop Series](#), underscoring the urgency in helping clinicians readily access kidney health data.ⁱ

Lessons from the CKCC model highlight the importance of timely exchange of clinical information across these settings. CKCC participants have identified situations in which a patient attributed to a KCC participant may transition between a hospital, skilled nursing facility, and dialysis facility without timely exchange of information regarding changes in the patient's clinical status, medications, functional status, or care plan. These gaps can limit the participant's ability to coordinate care and improve performance on measures such as Optimal ESRD Starts, home dialysis and home dialysis training, ESRD-related hospitalizations, and medication adherence. Similarly, limited access to information about a patient's clinical status or treatment preferences can make it challenging for participants to identify patients who could benefit from timely transplant evaluation or preemptive waitlisting, despite being accountable for measures related to preemptive waitlisting and transplantation.

For a future kidney specific payment model, CMMI should build on these lessons by ensuring that participants have timely access to the cross-setting clinical information necessary to manage attributed populations and coordinate care effectively. The future model should promote interoperable exchange of relevant clinical information across hospitals, skilled nursing facilities, dialysis facilities, nephrology practices, and other care settings, including information on clinical status, medications, functional status, treatment preferences, and care plan, while noting this may require considerable new investment, particularly for smaller participants. This should align with other HHS initiatives in this area, such as the aforementioned ongoing Advancing Kidney Data Standards and Interoperability initiative with the Office of the National Coordinator for Health IT.

4. Prospective Cash Flow Mechanics and Capitation Options

ASN supports incorporating prospective payment mechanisms, including elements of LEAD's capitation approach, into a future kidney-specific payment model. Traditional

FFS payment structures often do not provide the upfront resources necessary for participants to invest in care transformation, particularly for populations with complex, chronic conditions such as CKD and ESRD.

LEAD's approach represents an important evolution away from retrospective FFS reimbursement by providing prospective monthly payments through mechanisms such as Total Care Capitation (TCC), Primary Care Capitation (PCC), and Non-Primary Care Capitation (NPCC). In particular, the NPCC offers a novel opportunity to provide participating specialists with direct prospective Per Beneficiary Per Month Payments (PBPM) from CMS on behalf of the ACO.

ASN believes the monthly NPCC framework could be adapted for nephrology within a future kidney-specific model, providing nephrology practices with predictable resources to invest in multidisciplinary care teams, including care coordinators, dietitians, and social workers, while supporting proactive CKD management and improved coordination for individuals with kidney failure. In adapting the NPCC framework to a future kidney specific model, CMS should ensure that the prospective payment appropriately recognizes the resources and nephrology infrastructure that nephrology practices need to participate successfully, including the care coordination required across settings.

ASN recommends that the prospective payment for nephrology practices be analogous to the Kidney Care Capitation (KCC) approach in the Comprehensive Kidney Care Contracting (CKCC) model. The payment should be at least two times the corresponding FFS reimbursement and updated annually using the Medicare Economic Index (MEI), particularly given the anticipated 10-year duration of the model. A prospective payment would provide nephrology practices with the resources necessary to make sustained investments in care coordination and infrastructure.

Given the anticipated 10-year duration of a future kidney-specific model, CMS should also build flexibility into the payment methodology to account for advances in kidney care that occur during the model period. Specifically, ASN recommends that CMS establish a mechanism to provide additional expenditures for new and innovative therapies, technologies, and treatments that are approved and become available during the model period. This approach would allow the model to accommodate significant advances in kidney care, while ensuring that participants are not financially disincentivized from adopting new treatments that may improve outcomes or delay disease progression.

As discussed in the previous data interoperability section, a future kidney-specific model should recognize that many of the highest-cost events in kidney care occur outside the traditional nephrologist-patient interaction, particularly during hospitalizations and stays in skilled nursing facilities (SNFs). Unanticipated dialysis starts, vascular access complications, and volume overload events frequently require coordination among nephrologists, hospitals, and SNFs; yet existing FFS and value-based payment

structures often reinforce fragmented care delivery rather than foster shared accountability. For example, in the Comprehensive ESRD Care (CEC model), hospitalizations accounted for approximately 40% of total costs incurred by ESRD Seamless Care Organizations (ESCOs).ⁱⁱ Therefore, CMS should explore mechanisms to strengthen financial and operational alignment among nephrologists, hospitals, and SNFs to improve care transitions, reduce avoidable utilization, and support better outcomes.

ASN encourages CMS to adapt LEAD's preferred provider and downstream risk arrangements to establish formal partnerships among nephrologists, hospitals, specialty provider groups (including transplant providers and surgeons), and SNFs. These arrangements could create shared accountability for hospital and post-acute care utilization and support coordinated inpatient-to-outpatient and post-acute transitions, timely exchange of clinical information, and more effective management of patients at risk for hospitalization or unplanned dialysis initiation. CMS should also consider how NPCC could provide prospective resources to support the care coordination activities required to manage patients across these settings. More broadly, LEAD's prospective payment mechanisms could support a more integrated kidney care continuum by enabling collaboration between nephrologists and primary care providers earlier in the course of kidney disease. For individuals with earlier stages of CKD, these resources could support timely referral, risk stratification, and interventions to slow disease progression before patients reach kidney failure.

5. Beneficiary Alignment and Aggregation

ASN supports LEAD's hybrid alignment methodology as a potential foundation for a future kidney-specific payment model. Prioritizing voluntary alignment while maintaining a consistent claims-based methodology provides beneficiaries with choice while establishing a predictable framework for participant accountability.

Attribution approaches within a kidney-specific payment model will require modifications to reflect the longitudinal and multidisciplinary nature of kidney care delivery. Unlike many other chronic conditions, kidney care spans the continuum from early CKD management through kidney failure, dialysis, and transplant care, with meaningful contributions from nephrologists, primary care providers, hospitals, and other care partners. Particularly as newer therapies managed by nephrologists change the trajectory of beneficiaries' health, attribution methodologies that rely primarily on primary care evaluation and management services may not fully capture established nephrologist-patient relationships or the role nephrologists play in managing complex kidney disease.

ASN encourages CMMI to explore kidney-specific attribution approaches that recognize meaningful nephrology engagement, including nephrology evaluation and management (E/M) services, the Monthly Capitation Payment (MCP), and Kidney Disease Education (KDE) services, where applicable. More timely and predictable attribution would enable

participants to proactively manage care, better align accountability with clinical responsibility, and support investments in care transformation.

CMMI should also consider how aggregation structures affect participation by smaller, independent, and rural nephrology practices. Under CKCC, KCEs could aggregate with other KCEs to meet beneficiary requirements and combine financial and quality performance. CMS should retain a similar aggregation mechanism in a future kidney-specific model, allowing practices to request aggregation with other participants to meet model requirements and manage population-based risk. This option will be important in ensuring that smaller practices that cannot independently meet model requirements or manage population-based risk can participate in the model and will result in broader participation. Aggregation should be established prospectively, with practices made aware of their aggregation partners before the start of the performance period, rather than relying on retrospective assignment. CMS should also preserve visibility into practice-level performance to ensure that aggregation does not obscure opportunities for improvement. Flexible participation options, transparent practice-level performance information, and safeguards to preserve visibility into practice-level outcomes will be important to ensuring that future kidney models remain accessible to a broad range of participants.

6. Medicare-Medicaid Dual-Eligible Integration

LEAD introduces a dedicated Medicare-Medicaid integration pathway through which CMMI partners structurally with State Medicaid Agencies to facilitate real-time data exchange and aligned financial incentives. ASN strongly supports CMMI's efforts to advance integrated care for beneficiaries dually eligible for Medicare and Medicaid. This emphasis is critically important in kidney care, as approximately half of Medicare beneficiaries with ESRD are dually eligible. Future kidney care models should continue to promote alignment across Medicare and Medicaid to improve care coordination, reduce fragmentation, and better meet the needs of this medically complex population.

7. Quality Measurement

Financial success in LEAD is closely tied to quality performance through an upfront 3% quality withhold across both Professional and Global risk tracks, using a mix of claims-based measures, patient experience surveys, and electronic clinical quality measures (eCQMs). Quality metrics in value-based kidney models must drive meaningful clinical behavior, incentivize guideline-concordant care, and focus on interventions that slow disease progression and improve long-term outcomes. ASN recommends carrying forward key clinical priorities from the Kidney Care Choices (KCC) model while expanding metrics to capture early-stage CKD management:

- **Optimal ESRD Starts:** ASN strongly recommends that CMS incorporate the Optimal ESRD Starts measure into future kidney care models. The KCC Model demonstrated that this measure effectively incentivizes earlier care planning and coordination, resulting in significant improvements in optimal transitions to kidney failure care through increased permanent vascular access placement and home

dialysis utilization. As CMS considers the use of this measure in future models, ASN recommends it be revised to recognize patients who initiate home hemodialysis (HHD), including those who begin HHD before surgical vascular access placement, or provide an appropriate grace period for permanent access placement following HHD initiation. CMS should also monitor the timing of dialysis initiation among model participants relative to non-model care to ensure that the Optimal ESRD Starts measure incentivizes appropriate advance planning and preparation for kidney failure, rather than earlier initiation of chronic dialysis.

- **Early CKD Screening, Monitoring, and Progression Delay:** To capture disease early, CMS should incorporate the Kidney Health Evaluation measure for at-risk populations with diabetes or hypertension. For patients with Stage 3 CKD or higher, ASN advocates for metrics assessing annual completion of a basic metabolic panel, serum albumin, serum phosphorus, and urine albumin-to-creatinine ratio (UACR). CMS should also incorporate a CKD progression measure, similar to the observed-versus-expected CKD progression measure used in the CKCC model, to assess whether interventions guided by participants are slowing progression to kidney failure among patients with established CKD. The model should utilize validated risk stratification equations and include both eGFR and albuminuria (UACR) to most accurately reflect baseline and ongoing CKD progression risk.
- **Timely Nephrology Referral:** In alignment with clinical guidelines, timely referral to a nephrologist significantly improves long-term outcomes. ASN advocates establishing a quality measure for referral at Stage 3b (eGFR < 45 mL/min/1.73m²) when accompanied by persistent albuminuria (UACR > 30 mg/g).
- **Optimization of Evidence-Based Medical Therapy:** Widespread adoption of disease-modifying therapies—including SGLT2 inhibitors, RAS inhibitors, mineralocorticoid receptor antagonists (MRAs), and GLP-1-related agents—can substantially slow CKD progression and reduce cardiovascular events and mortality. CMS should incentivize appropriate utilization and adherence through metrics that account for individual clinical exclusions (such as hyperkalemia, advanced CKD, tolerability issues, or cost barriers). The model should also account for patient access to these therapies, particularly medications covered under Medicare Part D. Coverage restrictions, cost-sharing, and other Part D barriers can limit patients' ability to initiate and maintain appropriate evidence-based treatment.
 - ASN notes that CMS has proposed adopting a new quality measure titled "SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD)"

With or Without Type 2 Diabetes Mellitus" as a MIPS Clinical Quality Measure (CQM) in the CY2027 Physician Fee Schedule ruleⁱⁱⁱ. ASN supports its adoption in the MIPS program and believes it would also be relevant to this model. Regrettably, the measure only includes CKD stage 2 and 3 patients (not CKD 4) but nonetheless may present an important advancement in kidney disease quality measurement.

- **Comprehensive Kidney Disease Education (KDE):** Patient education among individuals with Stage 4 CKD—and Stage 5 with appropriate program waivers—increases rates of optimal dialysis transitions, home dialysis uptake, conservative management, and preemptive transplant evaluations. ASN encourages CMS to expand the pool of professionals eligible to provide KDE beyond physicians, nurse practitioners, clinical nurse specialists, and physician assistants to include registered nurses and other qualified members of the interdisciplinary care team. CMS should establish a quality metric tracking utilization of KDE billing codes.
- **Preemptive Kidney Transplantation Referrals:** Preemptive kidney transplantation yields superior clinical outcomes and cost savings compared to both post-dialysis transplantation and particularly long-term maintenance dialysis. The future kidney model should feature quality metrics evaluating timely transplant evaluation referrals for patients reaching $\text{eGFR} < 20 \text{ mL/min/1.73m}^2$, alongside structural measures such as the Standardized Transplantation Referral Ratio. CMMI should also reinstitute the transplant bonus used in the CKCC model to incentivize transplantation and support the care coordination and infrastructure needed to increase transplant rates.
 - ASN provides more detailed recommendations on how CMMI can strengthen transplant integration and accountability in the accompanying **addendum** of this letter.

Adapting CARA for Nephrology Participation in LEAD

1. Rationale and Core Objective:

ASN commends the CMMI for identifying kidney care as a potential area of focus for the CMS-Administered Risk Arrangements (CARA) framework within the LEAD model. CKD and ESRD, including dialysis and kidney transplantation represent some of Medicare's most clinically complex and costly conditions, yet there remain significant opportunities to improve care coordination, slow disease progression, increase the uptake of home dialysis and transplantation, and reduce avoidable hospitalizations. Because nephrologists manage patients across the continuum of kidney disease and routinely coordinate care with primary care clinicians, specialists, dialysis facilities, hospitals, and transplant centers, kidney care is well suited for a specialty-focused accountability

model that rewards high-value, coordinated care. However, the proposed CARA framework appears to be designed as a broadly applicable specialty model and may not fully account for the longitudinal nature and unique clinical and operational characteristics of kidney care. Accordingly, kidney-focused CARAs will require modifications to beneficiary attribution, financial benchmarking, quality measurement, and risk adjustment to appropriately reflect the realities of kidney care delivery. Unlike specialties focused primarily on discrete episodes of care, nephrologists often manage patients over many years as they progress from advanced CKD through kidney failure, dialysis, transplantation, and post-transplant care. Accordingly, kidney-focused CARAs will require refinements to beneficiary attribution, financial benchmarking, quality measurement, and risk adjustment to appropriately reflect the realities of kidney care delivery.

If appropriately tailored, CARA could also provide an important pathway for expanding specialty participation in value-based care. Many nephrology practices—particularly small and independent practices—have demonstrated interest in value-based payment but remain hesitant to participate in models that require substantial actuarial expertise, complex contracting, or immediate exposure to significant financial risk, reflecting that these practices care for a relatively small number of high cost, high complexity patients. For CARA to serve as a meaningful pathway for nephrology participation in LEAD, kidney-focused opportunities should be available at the launch of the model in 2027, rather than being phased in over subsequent years. By providing standardized contracting infrastructure, transparent benchmarking methodologies, and graduated approaches to financial accountability from the outset, tailored to the unique needs of kidney care, CARA has the potential to lower barriers to participation while allowing nephrologists to progressively build experience managing financial risk.

2. Key Structural Modifications to CARA

Targeted Beneficiary Population & Risk Adjustment

ASN recommends that kidney-focused CARAs align beneficiaries based on clinically meaningful kidney disease populations rather than attributing these beneficiaries solely through the broader LEAD model population. Beneficiary alignment should focus on individuals with advanced CKD, kidney failure, and kidney transplant recipients, as these populations have the greatest opportunity to benefit from coordinated nephrology-led interventions. Targeted attribution would ensure nephrologists are held accountable for beneficiaries whose care they meaningfully influence while avoiding fragmented accountability across providers.

CARA's risk adjustment and attribution methodologies should be refined to reflect the complexity of kidney care delivery and the populations served by nephrology practices. Beneficiaries with advanced CKD, kidney failure, and kidney transplants frequently transition across multiple care settings, including dialysis facilities, hospitals, skilled nursing facilities, and transplant centers, creating challenges for accurate attribution and

accountability. CMMI should evaluate whether additional refinements are needed to the ESRD CMS-HCC model to capture factors that influence resource utilization and outcomes in kidney care, including disease severity, kidney replacement modality, transplant status, multimorbidity, and social risk factors. Accurate attribution and risk adjustment will be essential to establishing fair benchmarks and ensuring that CARA encourages participation by nephrology practices caring for complex beneficiaries.

CMMI should also establish clear minimum volume thresholds for kidney-focused CARAs to ensure that participating practices have a sufficient number of eligible beneficiaries and qualifying episodes to support reliable benchmarking and meaningful accountability. Any volume thresholds should be developed specifically for kidney care and should account for differences in the size and composition of nephrology practices, particularly small and independent practices. CMS should avoid thresholds that inadvertently exclude practices with substantial expertise in kidney care but lower absolute patient volumes. Where individual practice volumes are insufficient, CMS should consider mechanisms that allow practices to participate through appropriate aggregation or other approaches that preserve statistical reliability while maintaining access to the model.

Tailored Financial Benchmarking & Stop-Loss Provisions

ASN encourages CMS to establish predictable, prospective financial benchmarks that provide participants with greater certainty regarding performance expectations throughout the model period. Frequent benchmark rebasing or significant year-to-year changes in financial targets can undermine provider confidence, discourage long-term investments in care management infrastructure, and reduce participation in specialty-focused value-based care arrangements.

Kidney care-focused CARAs should also include specialty-specific financial protections that recognize the substantial cost variability associated with advanced kidney disease. CMS should consider incorporating appropriately designed risk corridors and stop-loss provisions that protect participants from catastrophic financial losses associated with unexpected dialysis initiation, vascular access complications, prolonged hospitalizations, transplant-related complications, or other high-cost events that may not be fully within the control of participating nephrology practices. These protections would encourage participation while maintaining meaningful accountability for care quality and total cost of care.

Flexible Risk Tracks for Varying Practice Size

ASN recommends that CMS establish graduated participation pathways that recognize the diversity of nephrology practice settings. While larger integrated practices may have the infrastructure and capital necessary to assume greater financial accountability, many independent nephrology practices face resource constraints that make immediate participation in advanced risk arrangements challenging.

Accordingly, CMS should offer tiered risk options that allow practices to begin with limited downside exposure and progressively transition to higher levels of financial accountability as they gain operational experience and develop the necessary care management capabilities. Providing a gradual pathway to risk would promote broader participation while preserving access to value-based care opportunities for independent nephrology practices.

3. Operational & Administrative Adaptations

Streamlined CMS Data Sharing and Billing Integration

Timely access to actionable data will be critical to the success of kidney-focused CARAs. ASN recommends that CMS provide participating practices with frequent beneficiary-level claims data, utilization reports, and performance feedback that enable proactive identification of patients at risk for disease progression, hospitalization, or kidney failure. More timely data sharing would allow nephrologists to intervene earlier, improve care coordination, focus on those at highest risk for adverse events, and reduce avoidable utilization while minimizing administrative burden associated with retrospective reporting.

Similarly, quality measurement within kidney-focused CARAs should emphasize specialty-relevant outcomes that reflect meaningful improvements in kidney care. Rather than relying primarily on broad primary care measures, CMS should evaluate performance using measures such as home dialysis utilization, optimal dialysis starts, preemptive transplant referral, transplant waitlisting, kidney transplantation, slowing CKD progression, and other clinically meaningful kidney-specific outcomes. Aligning performance measurement with nephrology practice will better reward high-quality care and support continued innovation in kidney disease management.

Multi-Payer Alignment Opportunities

To maximize the impact of CARA, ASN encourages CMS to explore opportunities for greater alignment across Medicare fee-for-service, Medicare Advantage, and commercial payers. Nephrology practices frequently manage patients insured through multiple payers, each with distinct quality measures, attribution methodologies, and financial arrangements. This fragmentation increases administrative burden and limits providers' ability to implement consistent care delivery strategies.

Where feasible, CMS should encourage participating Medicare Advantage organizations and commercial insurers to adopt similar attribution methodologies, quality measures, benchmarking approaches, and financial structures. Greater multi-payer alignment would simplify model participation, reduce administrative complexity, and enable nephrology practices to deliver more consistent, patient-centered care across their entire patient population.

ASN believes that appropriately tailoring CARA for nephrology would meaningfully advance CMMI's goal of expanding specialty participation in accountable care while

recognizing the unique characteristics of kidney disease. By incorporating kidney-specific beneficiary attribution, robust risk adjustment, predictable financial benchmarking, flexible participation pathways, timely data sharing, and clinically meaningful quality measures, CMS can create a model that supports both improved patient outcomes and sustainable specialty participation in value-based care.

As CMS continues to develop the CARA framework, ASN strongly encourages CMMI to engage nephrologists, dialysis providers, transplant clinicians, and other kidney care stakeholders in the design of kidney-specific model parameters, quality measures, attribution methodologies, financial benchmarks, and risk thresholds. Early collaboration with the kidney community will help ensure that CARA is operationally feasible, clinically meaningful, and capable of achieving its intended goals of improving quality while reducing Medicare expenditures.

Conclusion

The experience of the CKCC model demonstrates both the promise of kidney-focused value-based care and the vital importance of maintaining a dedicated pathway for patients with advanced kidney disease and ESRD. As CMMI plans the future of value-based care, ASN encourages CMMI to consider either of two distinct, non-mutually exclusive pathways to sustain specialty-driven kidney care:

- **Option 1: Leveraging LEAD as a Chassis for a Next-Generation Kidney Payment Model** CMMI could leverage LEAD's 10-year framework, prospective capitation mechanisms, and clear, accurate baseline benchmarking to serve as the foundational chassis for a next-generation, standalone kidney-specific payment model.
- **Option 2: Adapting CARA for Nephrology Participation in LEAD.** Alternatively, if CMMI focuses on specialty integration within broad ACO structures, CMMI could refine CARA's beneficiary attribution, risk adjustment, and financial stop-loss provisions to create an accessible, flexible entry point for nephrologists to participate directly in LEAD.

Whether CMMI chooses to construct a dedicated kidney model on the LEAD chassis and/or refine the CARA framework for specialty integration, the ultimate goal must be preserving specialized accountability for complex kidney populations. ASN strongly encourages CMMI to engage nephrologists and kidney care stakeholders as it evaluates these approaches to ensure any future model parameters are operationally feasible, clinically meaningful, and designed to improve patient outcomes while reducing Medicare expenditures.

ASN commends CMMI for its efforts to expand nephrology participation in value-based care and appreciates the opportunity to provide these recommendations as CMMI considers the future of kidney-focused value-based care following the conclusion of the KCC Model. ASN stands ready to provide additional information or engage its expert

members as CMMI considers these approaches. Please contact ASN Senior Policy and Government Affairs Associate Lauren Ahearn at lahearn@asn-online.org to discuss this letter or ASN's recommendations further.

Sincerely,

A handwritten signature in black ink, appearing to read "Sam M. Parikh".

Samir M. Parikh, MD, FASN
President

ⁱ [Advancing Kidney Data Standards and Interoperability: From Discovery to Action - ONC - Office of the National Coordinator for Health Information Technology](#)

ⁱⁱ [Findings at a Glance for the Synthesis of Evaluation Results across 21 Medicare Models, 2012-2020](#)

ⁱⁱⁱ [Federal Register :: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program](#)

Addendum to Leveraging Components of the Long-Term Enhanced ACO Design (LEAD) Model for Future Kidney Specific CMMI Model Comments- Transplant Recommendations

Strengthening Transplant Integration and Accountability

Future models should more fully integrate transplant centers into kidney care payment reforms and establish shared accountability for transplant-related outcomes. Current KCC incentives for transplantation are primarily directed toward nephrology practices and dialysis providers, while transplant centers often operate outside the core financial and operational structure of the model yet have the ultimate control over which patients are added to the waitlist and receive a transplant.

Establishing shared accountability for transplant referral, evaluation, waitlisting, and transplantation could improve coordination between referring providers and transplant programs. Future models should also encourage interoperable communication systems between dialysis facilities and transplant centers to support timely exchange of clinical information (a goal that ASN has previously encouraged HHS to work towards more broadly). Improved integration across these providers would help ensure that incentives to increase transplant referrals translate into meaningful improvements in transplant access rather than simply increasing administrative burden on transplant programs.

ASN suggests that CMMI consider a shared accountability model that creates incentives for a population of people with kidney diseases that includes transplant nephrologists and transplant programs, community nephrologists, and dialysis organizations. Building on the goals of both KCC and IOTA, such a model would aim to increase patient access to transplants, improve the patient experience of care, and create efficiencies that speed the time to transplant (among other goals across the patient's journey discussed elsewhere).

For example, in such a model, the community nephrologists and dialysis organizations could assume greater responsibility for pre-transplant care coordination and testing arrangements, be involved in care post-transplant (for example, treating delayed graft function), and provide ongoing care for stable, post-transplant patients. While in the current FFS payment system, these activities are not well-remunerated for these key stakeholders, in the context of a payment model (such as a capitated model) they may make more sense holistically. In many ways, the dialysis unit is the ideal environment to help keep potential candidates healthy and ready for transplantation, up-to-date on needed testing, and apprised of their status with the transplant center: most in-center hemodialysis patients visit three times per week and home dialysis patients visit at least once monthly, the units are staffed with social workers, nurses, and others who have longitudinal relationships with patients and have the expertise to help guide patients, and lab test-ordering capabilities exist.

Meanwhile, participating transplant centers would be incentivized to get patients through the consideration process faster and transplant nephrologists would be able to focus their time on achieving that goal pre-transplant, as well as helping the most complex

patients post-transplant (with community nephrologists helping care for stable patients post-transplant).

Such a model would also be the ideal place to test changes to metrics currently used across these stakeholders that may sometimes work at cross-purposes with each other. For example, ASN recommends excluding high-risk patients (such as a high EPTS score) and high-risk kidneys (such as high KDPI) from the model's performance metrics, and, ideally exempting participating centers from MPSC metrics during the model's performance periods. Excluding them from the waitlist mortality metric in particular would be important to allow for more liberal waitlisting practices, and to remove a misaligned incentive with the dialysis unit PPPW metric.

Savings could derive from what would have otherwise been expected to be spent on dialysis as well as reduced unnecessary lab testing for pre-transplant patients. While the transplant-focused aspects of a model with these stakeholders could span the entirety of the patient journey from late-stage kidney disease onward, CMMI could also consider more discrete "phases," to involve these stakeholders along the patient journey, such as:

- Pre-transplant: dialysis units, general nephrologists, and transplant centers
- Post-transplant (0 to 90-days): transplant centers, transplant nephrologists, dialysis units
- Post-transplant long-term: transplant centers, community nephrologists

As alternative approaches to a capitated payment model that still aim to improve care (particularly post-transplant care) CMMI could create a Monthly Capitated Payment (MCP) for post-transplant care for community nephrologists. With a secure, regular revenue stream for post-transplant care as there is in dialysis care, community nephrologists will be more able to dedicate time to the essential posttransplant care of stable kidney transplant recipients. CMMI could also institute an RVU adjustment for the care of transplant patients attributed to the model regardless of the nephrologist type, providing the care (e.g. transplant or general nephrologist). ASN would be pleased to work with CMMI and the broader kidney care community to help specify what this upward adjustment would appropriately entail to reflect the complexity and uniqueness of post-transplant care provided in the community setting

The society emphasizes that success in aligning stakeholders to better foster access to kidney transplantation—within a model or in general—hinges on improved communications capabilities and interoperability between dialysis organizations, transplant centers, and nephrology practices. For example, dialysis organizations or community nephrologists can only meaningfully help a patient remain transplant-ready if they can confirm whether a patient is active on the waitlist—just one example of a barrier that exists at present that is imminently solvable through data standards and technology adoption.