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Abe Sutton
Director of the Center for Medicare and Medicaid Innovation
Deputy Administrator for the Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Tom Duvall
Division Director, Seamless Care Models Group
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

RE: Kidney Care Choices (KCC) Model

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), thank you for your leadership on, and commitment to, kidney health.

ASN appreciates the Center for Medicare & Medicaid Innovation's (CMMI) efforts to test innovative payment and care delivery models to improve outcomes for patients with chronic kidney disease (CKD) and end-stage renal disease (ESRD). The Kidney Care Choices (KCC) Model was developed as part of a broader federal effort to transform kidney care through value-based payment reform and improve care coordination across the CKD continuum, spanning non-dialysis CKD, dialysis, and kidney transplantation.

To provide guidance on the model's implementation and future development, ASN convened a group of expert nephrologists with experience in value-based care and payment model design, including nephrologists who currently participate in the KCC model. In this letter, ASN reviews the model's early performance, highlights areas of success, identifies challenges and unintended consequences, and offers definitive recommendations for how future iterations of kidney care payment models should build on lessons learned. ASN's intent with this letter is to help inform the next iteration of the KCC and to serve as a resource to CMS on model design.

Executive Summary

ASN appreciates CMMI's continued efforts through the Kidney Care Choices (KCC) Model to improve outcomes for individuals with CKD and ESRD and supports the model's overarching goals of advancing value-based kidney care. The KCC Model has demonstrated promising impacts across several domains, including improvements in optimal dialysis starts, increased preemptive waitlisting and transplantation, greater adoption of home dialysis modalities, and strengthened care coordination and patient education. These findings suggest that appropriately structured incentives can meaningfully influence care delivery across the kidney disease continuum.

ASN offers detailed comments in the letter below and the Society's key recommendations are as follows:

1. **Strengthen benchmark stability and financial predictability** by limiting retrospective adjustments, establishing clear trigger thresholds, using appropriate CKD- and ESRD-specific reference populations, and maintaining risk corridors to reduce volatility and support long-term participation.
2. **Refine incentive and payment design to better align with disease trajectory**, including greater emphasis on early CKD intervention, delayed progression to kidney failure, and longer-term evaluation of savings associated with transplantation and disease-modifying therapies.
3. **Address operational and attribution barriers that limit participation and care delivery**, including delays in attribution, limited care coordination access in SNFs and dialysis settings, and administrative complexity that disproportionately affects smaller and rural practices.
4. **Expand transplant integration and system capacity**, including stronger alignment between nephrology practices and transplant centers, preservation of transplant-related incentives, and attention to workforce constraints in post-transplant care.
5. **Broaden participation and improve model accessibility**, particularly for smaller practices, academic centers, and underserved regions, through targeted technical assistance, simplified reporting, and improved infrastructure support.
6. **Enhance alignment with the full Medicare population**, including consideration of Medicare Advantage beneficiaries to improve representativeness, participation feasibility, and generalizability of results.

ASN believes the KCC Model has generated important progress in advancing kidney care transformation. With refinements to financial design, operational structure, and incentive alignment, future iterations of the model can more effectively improve outcomes, expand access to high-quality care, and support long-term sustainability.

Model Successes

Optimal Starts

The KCC model demonstrated clear and compelling improvements in clinical outcomes, most notably, higher rates of optimal transitions to care for kidney failure. The second evaluation report found that the model increased the rate of "Optimal ESRD Starts" by 12.4 percentage points relative to the comparison group, which represents a significant 31 percent increase compared with the pre-model baseline[i].

Improvements in transitions to dialysis were primarily driven by increased placement of permanent vascular access prior to dialysis initiation and greater utilization of home dialysis modalities, both of which are care delivery patterns associated with lower hospitalization and mortality rates[ii]. By facilitating earlier education, planning, and placement for home dialysis, the KCC model contributed to more patient-centered care as well as improved long-term clinical outcomes that can reduce longer term per beneficiary per year costs.

Improved Transplant Outcomes

Consistent with the excellent performance improvement observed with the Optimal ESRD Starts measure, the model also increased preemptive waitlisting by 40% and increased preemptive kidney transplants by 69%, enabling more patients to receive transplants at earlier stages of kidney failure and potentially avoid dialysis altogether[i]. Similarly, living donor kidney transplants rose by 22%[i]. Kidney transplantation not only improves patient quality of life and longevity

relative to dialysis, but also is cost-effective, even when considering higher costs for marginal organs and innovative living donor practices[iii].Taken together, these KCC-attributable improvements in transplant-related outcomes demonstrate meaningful potential for the model to simultaneously improve patients' access to optimal therapy while delivering savings over time, albeit requiring a far longer time horizon than is readily measured in a model like KCC.

Increased Adoption of Home Dialysis Modalities

Participation in the model was associated with increased adoption of home dialysis modalities and increased home dialysis training. In PY 2023, the KCC model increased the rates of home dialysis by 10 percent and decreased use of in-center hemodialysis by 1 percent. While home dialysis has been gradually increasing nationally, the model's financial incentives and care coordination structures may have accelerated this trend among participating organizations. While home dialysis is associated with lower total cost of care over time due to reduced facility utilization and resource intensity, patients must retain ongoing full access to adequate education and support in order to choose the modality that best aligns with their clinical needs, lifestyle, and preferences. It is evident that these crucial elements have been both supported and encouraged through the KCC model's emphasis on education and care coordination.

Strengthened Care Coordination and Patient Education

Evaluation findings and participant interviews suggest that the model has also encouraged stronger care coordination across the CKD continuum. Participating organizations reported more frequent advanced CKD visits focused on modality education and earlier referral for vascular access placement. In many cases, practices utilized multidisciplinary care teams and care navigators to provide patient education, follow up with patients after modality discussions, and coordinate care across nephrology practices, dialysis facilities, and transplant centers.

Strong Voluntary Participation

The model has maintained relatively strong voluntary participation since its launch, particularly in its early years. The KCC model offers multiple participation options with varying levels of financial risk, allowing organizations entering the model to select KCE tracks aligned with their operational capacity and risk tolerance. This flexibility has helped attract participation from nephrology practices and kidney care organizations seeking to invest in value-based care approaches in kidney disease management.

Model Weaknesses and Proposed ASN Solutions

While ASN strongly believes the KCC model has demonstrated promising results in several of the model's key goals, the society has also identified structural and operational challenges that limited the model's effectiveness and scalability, contributing to participant attrition in the later years of the model. Addressing these issues will be important as CMMI considers future iterations of kidney care payment models. ASN's recommendations to address these challenges are included below.

Benchmark Methodology & Financial Predictability

The success of the KCC model depends on nephrologists having adequate resources and incentives to achieve the program's goals. To manage performance effectively, participants require financial benchmark methodology and data that are stable and transparent throughout the duration of the model This includes not only the benchmarks themselves, but also clear, consistent, and aligned methodologies for how performance against those benchmarks is measured and assessed over time.

A key concern with the model is the lack of predictability and stability in its financial benchmarking methodology. This concern stems in part from reliance on historical utilization data that may not fully reflect current or evolving patterns of care delivery across the CKD and ESRD populations. In addition, uncertainty in how benchmarks and associated performance metrics are calculated and assessed may contribute to discrepancies between CMS and participants in evaluating outcomes. As a result, benchmarks may be sensitive to shifts in clinical practice, patient mix, and broader care system dynamics, creating uncertainty in performance over time. In a model that depends on multi-year investments in care transformation, this lack of stability makes it more difficult for participants to plan and sustain interventions aimed at improving outcomes.

In addition, in 2024, CMS announced a retroactive trend adjustment (RTA) to the PY 2022 and PY 2023 benchmarks due to discrepancies between projected and actual healthcare expenditures, which further contributed to the financial unpredictability of the model. These discrepancies were caused by the agency's use of pre-pandemic (2017 to 2019) utilization data, which did not account for the substantial decline in healthcare utilization during the COVID-19 pandemic. The decision to apply this adjustment retroactively resulted in reduced funding for patient care after the performance period had concluded and after nephrologists had made significant investments to improve outcomes, undermining participant confidence.

If retroactive trend adjustments are retained in future models, ASN believes they must be clearly defined, limited in scope, and operationalized in a manner that preserves participant confidence and financial predictability.

- ***Trigger Threshold for the Application of RTA:*** CMS should establish a predefined trigger threshold for applying retroactive trend adjustments that is transparent to potential participants before they commit to the model. Under this approach, RTAs would be applied only when observed expenditures deviate from projected expenditures beyond a clearly defined tolerance, such as 1 percent. This approach would mirror the ACO REACH Model, where retroactive adjustments are triggered only for meaningful deviations, ensuring predictability for participants and preventing minor spending fluctuations from prompting revisions. Applying a similar threshold in the KCC Model would reserve retroactive adjustments for systematic discrepancies, improve methodological consistency, and reduce the likelihood of corrections to completed performance years.
- ***Reference Populations:*** Like benchmarks, RTAs should be calculated using reference populations that appropriately reflect the clinical and utilization characteristics of the beneficiaries in the model. The reference population used in prior RTA calculations relied on the general Medicare population, which differs materially from the ESRD population. To address this, CMS should calculate a CKD-specific RTA based on the Traditional Medicare advanced CKD population not attributed to a longitudinal model at the same stage of CKD as beneficiaries in the model, and an ESRD-specific RTA based on the Traditional Medicare ESRD population not attributed to a longitudinal model, excluding the approximately 40 percent of Traditional Medicare beneficiaries currently attributed to the CKCC model.
- ***Risk Corridors:*** If CMS continues to use RTAs it also should continue the use of risk corridors, which limit participant risk in a budget-neutral manner and provide defined parameters of and limits to financial exposure that apply consistently year-over-year. For ESRD populations, where annual spending per patient often exceeds $100,000, risk corridors are particularly important to provide reasonable financial protection to participants—especially smaller ones—to enable them to join the model.

- ***Ongoing Reporting and Transparency:*** CMS should provide participants with monthly reporting on performance trends relative to expected spending benchmarks, including the underlying drivers that may inform potential benchmark adjustments such as RTAs. This reporting should include two commentary components:
    (1) aggregate performance and utilization trends for CKD and ESRD beneficiaries not aligned to the model, which would help participants anticipate broader spending patterns that may inform future RTAs; and
    (2) participant-level performance and utilization data, which would support timely decision making, care coordination and management, and financial forecasting within the model

This approach is consistent with the ACO REACH Model, where participants receive regular, claims-based performance and utilization data throughout the performance year to support timely decision making and more accurate forecasting

Refining Model Design and Incentive Structure
In addition to challenges related to benchmarking methodology, ASN has identified several areas where the model's financial design and incentive structure could be refined to better align with patient outcomes, improve predictability, and support effective care delivery.

Phased Approach to Risk
ASN recommends CMMI maintain a multi-track participation framework that allows participants to select among options with varying risk exposure, including an option with a longer implementation period as well as an option for full risk participation.

For participants in the longer implementation pathway, ASN supports a gradual approach to financial accountability, such as a period of at least one year without downside risk exposure, followed by a phased increase in risk as organizations build operational capacity, strengthen care coordination, and gain experience with model benchmarks and performance measurement. A longer implementation period runway would provide participants with sufficient time to build the infrastructure needed for effective population-based care management.

Payment Design and Incentive Structure:
Several aspects of the model's financial design may create misaligned incentives or limit participants' ability to invest in care transformation:

- ***Discount Structure***: the current discount approach may not fully reflect the high baseline costs and clinical complexity of ESRD populations. In addition, the abrupt transition from CKD to ESRD benchmarks may not align with the realities of the first year of dialysis. A more gradual transition and re-evaluation of discount methodology could better support high-quality care transitions.
- ***CKD Incentives****:* Current benchmarking dynamics may result in CKD populations having fewer opportunities to result in cost savings relative to ESRD populations, as lower baseline spending and the upfront costs associated with slowing disease progression are neither immediately nor fully reflected in performance-year benchmarks, since avoided progression to ESRD is not directly captured in measured savings, and the effects of interventions with associated upfront costs may be delayed. This misalignment risks undermining the goal of slowing disease progression. Strengthening incentives for maintaining patients in earlier stages of CKD would better support early intervention. In addition, comparing CKD progression rates among participants compared to traditional Medicare CKD beneficiaries can capture long-term cost savings.

- **Attribution and Alignment Accuracy**: Delays in alignment data and retrospective dealignment can result in uncompensated care and reduced confidence in the model. Improving the timeliness and accuracy of attribution, and exploring mechanisms to account for attribution lag, would better align payment with care delivery.
- **Cash Flow and Payment Timing**: The existing payment structure may not provide sufficient prospective cash flow to support investments in care coordination and infrastructure. Introducing prospective or capitated payment mechanisms could better align payment timing with care delivery needs and allow for investment in necessary resources to implement care delivery enhancements.

Physician Led and Hybrid Models

ASN encourages CMMI to explore physician-led or hybrid models that place nephrologists at the center of care coordination efforts while maintaining collaboration with dialysis facilities and other partners. Physician-led approaches may offer opportunities to promote care transformation across the CKD continuum without relying primarily on dialysis organizations as the central organizing structure. Prior experience with the Kidney Care First (KCF) model underscores the importance of careful model design to support this approach. Although KCF attempted to advance a physician-centered model, it was underutilized due in part to challenges with clinician attribution, particularly in the context of physician turnover, as well as the inability to reliably identify and include transplant nephrologists. These limitations constrained participation and hindered effective engagement of physicians in care coordination. These lessons should inform the design of future physician-led or hybrid models.

Mitigating Against Unintended Consequences Related to ESRD Transition

The model's quality metrics place substantial emphasis on dialysis transition rather than earlier intervention to slow disease progression. Measures such as Optimal ESRD Starts encourage dialysis initiation with permanent access or home modalities rather than catheter-based initiation. ASN espouses continued focus on Optimal Starts in a future model, though cost savings estimates should incorporate long-term cost savings associated with catheter avoidance and home dialysis utilization.

More broadly, the model initially included relatively limited incentives tied to slowing CKD progression or implementing disease-modifying therapies earlier in the course of illness. Therapies such as sodium-glucose cotransporter-2 (SGLT2) inhibitors and renin-angiotensin aldosterone system (RAAS) inhibitors have demonstrated the ability to slow CKD progression, yet the model's early design focused more heavily on dialysis and transplant transition metrics. As a result, the incentive structure may not fully support the model's goal of delaying the onset of kidney failure.

To address this issue, future kidney care models should place greater emphasis on slowing CKD progression and preventing kidney failure as outlined in the Trump administration's Advancing American Kidney Health Initiative[iv]. While the KCC Model improved preparation for dialysis, incentives for earlier-stage CKD management were limited. The incorporation of measures such as proteinuria/albuminuria monitoring, stage-specific CKD care metrics, timely nephrology referral, and evidence-based pharmacologic therapies, including SGLT2 inhibitors and RAAS inhibitors, mineralocorticoid receptor antagonists (MRAs), and GLP-1 receptor agonists, would encourage earlier intervention, reduce cardiovascular risk, and promote proactive disease management. Aligning payment incentives with the appropriate use of these therapies could accelerate their adoption and improve long-term patient outcomes[v]. In addition, studies to date have demonstrated long-term cost savings with utilization of SGLT2 inhibitors for patients with chronic kidney disease[vi].

Given this focus on the benefits to patients from intervening earlier in those at risk for advanced kidney disease, future models may also benefit from greater engagement with primary care providers and other clinicians who play a key role in early CKD detection and management and/or emphasis on technology adoption or partnerships for identifying at-risk patients. Expanding payment reform efforts to incentivize earlier referral for patients who would benefit from nephrology care to improve CKD detection, strengthen care coordination, and ensure that patients receive appropriate management before reaching advanced stages of disease. Without explicit financial alignment, quality measures alone may be insufficient to drive consistent adoption of disease-modifying therapies across diverse practice settings. ASN reiterates the importance of accounting for long-term cost savings through delaying and, in some patients, avoiding transition to dialysis.

Aligning incentives with long-term kidney disease trajectory

ASN recognizes the importance of fiscal stewardship and does not suggest abandoning accountability for cost; rather, the society encourages model designs that align accountability time horizons with the natural history of kidney disease. Future models should balance expectations regarding cost savings with the goal of improving patient outcomes and quality of care. CKD is a slowly progressive condition, and meaningful changes in disease trajectory or associated costs may not be observable within one- or two-year performance periods. Kidney transplantation similarly involves high upfront costs in the first year, while clinical and economic benefits accrue over a much longer time horizon. In addition, transplant recipients are often among the lowest-cost patients while on dialysis, which can further obscure near-term savings despite substantial long-term value.

Interventions that improve care for patients with CKD, including use of therapies that slow disease progression, patient education, enhanced care coordination, and multidisciplinary care teams, require upfront investment and may not yield measurable cost reductions in the short term. Models that rely on short performance windows therefore risk undervaluing interventions that delay disease progression or support successful transplantation. ASN recommends that CMMI incorporate longer-term, actuarially grounded assumptions into model design, including approaches that recognize the sustained value of maintaining patients in earlier stages of CKD or in a functioning transplant state. Aligning financial benchmarks with the long-term nature of kidney disease progression will better support meaningful improvements in care while maintaining realistic expectations for the timing of cost savings.

In addition, ASN encourages CMMI to ensure that future model design supports patient-centered care for individuals with advanced kidney disease, including earlier access to goals of care discussions, symptom management, and supportive care services. Many beneficiaries, particularly those in subacute settings, would benefit from a more deliberate focus on aligning treatment decisions with their values. To support this, CMMI should address existing disincentives to palliative and supportive care by aligning patient preferences with appropriate care team engagement and considering payment incentives that promote patient-centered care. While ASN supports prior efforts to expand access to hospice through the concurrent care benefit enhancement, uptake has been limited. Improving access will require reducing administrative and contractual barriers so patients can maintain choice of nephrologist, dialysis, and hospice providers. Together, these steps would improve patient experience, support informed decision making, and ensure care delivery under value-based models remains aligned with patient goals and clinical need.

Operationalizing this longer-term approach will require greater transparency in how CMMI evaluates model performance; accordingly, ASN urges CMMI to clearly communicate how it will calculate the financial impact of future kidney care models, including the specific methodologies, assumptions, and time horizons used to assess savings. Providing clarity on when and how evaluation findings will be released would further strengthen stakeholder confidence and enable more effective participation. The Society also encourages CMMI to assess longer-term savings and quality outcomes from the KCC model following its conclusion, including, where feasible, through post-model evaluation activities, in order to better capture downstream impacts such as delayed disease progression, reduced hospitalization, and sustained transplant success.

ASN also encourages CMMI to provide greater transparency regarding how existing and future payment models may interact with or influence the design, benchmarking, and evaluation of kidney care models. As multiple models increasingly overlap, greater clarity on how CMMI accounts for these interactions will help stakeholders better understand incentives, avoid unintended consequences, and effectively participate in kidney-focused models.

Operational Barriers

As originally designed, the model's structure may inadvertently favor larger nephrology organizations and those with existing partnerships with larger dialysis providers. Participation often requires substantial administrative infrastructure, data analytics capabilities, and care coordination resources. Smaller nephrology practices and some academic centers may therefore face greater barriers to participation, potentially limiting the diversity of organizations represented in the model and reducing its overall scalability. These barriers may also exacerbate geographic and socioeconomic inequities in access to value-based kidney care, particularly in rural and underserved communities.

From ASN's perspective, a significant operational barrier to effective care delivery under the KCC Model is the limited ability of care coordination teams to access attributed beneficiaries who are residing in skilled nursing facilities (SNFs) or receiving dialysis care through large dialysis organizations (LDOs) in instances where they are not partners in the KCE. These beneficiaries frequently represent medically complex, high-risk populations for whom timely care coordination is most critical. However, current operational and contractual constraints often restrict meaningful engagement by KCE-affiliated care teams, thereby limiting the model's ability to improve outcomes, manage transitions of care, and reduce avoidable utilization. ASN recommends that future kidney care payment models include clear requirements to ensure that SNFs and dialysis organizations permit appropriate, timely access for care coordination teams to engage attributed beneficiaries, consistent with patient consent and applicable privacy protections.

Finally, delays in performance reporting limit participants' ability to respond to emerging trends. Evaluation reports released several years after the performance period provide valuable retrospective analysis but offer limited opportunity for participants to adjust care delivery strategies in real time.

Expanding Participation Across the Nephrology Community

Broad participation across the nephrology community will be essential to ensuring that future kidney care payment models are scalable and representative of the diverse settings in which kidney care is delivered. The experience of the KCC Model suggests that participation has been concentrated among larger organizations and those with established partnerships with dialysis providers.

Future models should seek to expand opportunities for participation among smaller nephrology practices, independent physician groups, and academic medical centers. These providers care for large and diverse patient populations and often serve communities with significant kidney disease burden. Ensuring their participation will help ensure that model results reflect the broader landscape of kidney care delivery.

CMMI should evaluate the financial, administrative, and operational barriers that may limit participation by these providers. In particular, smaller practices may lack the infrastructure required to manage population-based payment arrangements, including data analytics capabilities, care coordination resources, and administrative support. Providing targeted technical assistance, simplified reporting requirements, and upfront payments to facilitate investment could help lower these barriers and encourage broader participation.

Encouraging participation from a wider range of providers will strengthen the generalizability of model results and help ensure that future payment reforms support innovation across the full nephrology workforce.

Enhancing Home Dialysis Utilization

ASN strongly supports policies and incentives that increase patient education on kidney failure treatment modalities, as evidence shows that education increases rates of home dialysis initiation. ASN encourages CMMI to strengthen and standardize modality education to reduce barriers to home dialysis selection. However, significant upstream barriers remain, including limited and inconsistent education that is often confined to patients with established CKD and does not reach individuals who “crash start” on hemodialysis in the hospital or initiate in-center hemodialysis without prior education, clinician bias toward in-center hemodialysis, fragmented pre-dialysis care, late referral to nephrology, historical path dependence favoring in-center hemodialysis, and inadequate multidisciplinary support for patients considering home therapies or medical care without dialysis. Consistent with findings from the IM-HOME study, education, resources, and care team support remain central and overlapping barriers for patients, care partners, and clinicians.

ASN further notes a related barrier is the loss of home dialysis continuity during acute illness and care transitions. For patients treated with peritoneal dialysis, hospitalization or discharge to rehabilitation or skilled nursing settings can precipitate an avoidable transition to in-center hemodialysis when local expertise, staffing, or operational capacity to support peritoneal dialysis is limited. Although these patients represent a relatively small proportion of hospitalized individuals, such transitions can be life-altering and often reflect systemic gaps in training and infrastructure to support peritoneal dialysis in acute and post-acute settings.

In a future iteration of the KCC, ASN encourages CMMI to consider approaches that support the ability of non-home settings to provide peritoneal dialysis; this will require coordination with acute and subacute care providers as well as sufficient volume to maintain clinical expertise. ASN also encourages CMMI to consider payment incentives that support the uptake and sustained use of home dialysis, including incentives that reduce barriers to maintaining patients on home modalities when clinically appropriate. Equally important is extending modality education to these settings so that patients who initiate dialysis urgently in the hospital or transition through post-acute care are informed about home dialysis options rather than defaulting to in-center hemodialysis.

Transplant Integration and System Capacity
The removal of the transplant bonus would be a substantial setback for physician practices and, by extension, for patients who could benefit from timely transplant referral and waitlisting. The bonus has functioned as a practical source of support for practices to build and sustain the operational infrastructure required for transplantation—particularly by investing in internal transplant coordinators who track eligibility, complete testing checklists, manage documentation, and maintain consistent communication with transplant centers. Without this targeted support, practices will have fewer resources and weaker incentives to perform the time-intensive work of facilitating evaluation, referral, and listing, especially in settings where margins are thin and staffing is already stretched. Because nephrologists must manage many competing clinical priorities across ESRD and its comorbidities, eliminating a dedicated transplant incentive risks deprioritizing transplantation as a top clinical priority, slowing progress toward earlier waitlisting and transplant, and widening variation in access across practices and communities.

Although the model includes incentives intended to encourage kidney transplantation, integration between nephrology practices and transplant centers has been inconsistent. Many KCEs did not include transplant programs as significant partners. As a result, nephrology practices participating in the model often have limited ability to directly influence transplant evaluation processes or listing decisions.

In addition, some transplant centers were unable to participate due to structural constraints or the relatively short timeline between model announcement and implementation. These factors have limited the degree to which the model can align incentives across the full continuum of kidney care.

The current incentive structure may also encourage increased transplant referrals without corresponding expansion in transplant center capacity. Without coordinated planning across nephrology practices and transplant programs, increased referrals may contribute to longer evaluation queues and extended waitlists, potentially diluting the intended impact of the model's transplant-related incentives.

Lastly, to the degree that KCC, IOTA, and other future kidney care models are successful in increasing transplant rates, the current transplant nephrology workforce will be increasingly outstripped in its ability to provide post-transplant care. Incentives to appropriately engage other health professionals in this care management are needed as the nation succeeds in growing access to the optimal therapy for kidney failure for most.

ASN provides more detailed recommendations on how CMMI can strengthen transplant integration and accountability in the accompanying **addendum** to this letter.

Medicare Advantage
ASN encourages CMMI to explore ways to include or, at least account for, beneficiaries enrolled in Medicare Advantage in future models. Following the passage of the 21st Century Cures Act, MA enrollment has surpassed 54 percent of Medicare-eligible ESRD beneficiaries receiving dialysis in 2025. The exclusion of this population limits the applicability of model results, limits the ability of many practices to participate due to insufficient FFS beneficiary numbers, and reduces opportunities to test interventions across the full Medicare population. Mechanisms could include aligning quality metrics, incorporating shared savings arrangements, or coordinating with MA plans. The inclusion of Medicare Advantage beneficiaries would enhance the model's ability to evaluate care innovations, promote equitable access to high-quality kidney care, and support CMMI's goals of improving outcomes and reducing costs.

ASN has offered detailed recommendations on strategies CMMI could consider to include MA patients in its February 2026 comments on the Improving Organ Transplant Access (IOTA) model[vii].

Conclusion

As the CMMI considers future kidney care payment models, ASN encourages CMS to build on the lessons learned from the KCC Model. Future models should maintain a focus on improving care coordination and expanding access to patient-centered treatment options while addressing structural challenges that limited the model's full potential. ASN believes strongly that a future iteration of the KCC model can improve long-term clinical outcomes and reduce costs, with a refined design and incentive structure.

Again, ASN commends CMMI for its leadership on KCC and stands ready to provide additional information or offer access to its expert members as CMMI considers future improvements to the model. Please contact ASN Policy and Government Affairs Coordinator Lauren Ahearn at lahearn@asn-online.org to discuss this letter or the KCC model more generally with ASN.

Sincerely,

Samir M. Parikh, MD, FASN
President

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[i] https://www.cms.gov/priorities/innovation/data-and-reports/2026/kcc-2nd-annual-report

[ii] https://pmc.ncbi.nlm.nih.gov/articles/PMC10719643/#:~:text=The%20overall%20survival%20at%20the,different%20between%20the%20study%20groups

[iii] Axelrod DA et al. An economic assessment of contemporary kidney transplant practice. Am J Transplant. January 2018. DOI: 10.1111/ajt.14702

[iv] Advancing American Kidney Health

[v] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2825778#:~:text=Findings%20This%20cost%2Deffectiveness%20study,initiation%20ages%20and%20screening%20frequencies.

[vi] Cost-effectiveness of sodium-glucose cotransporter 2 inhibitors in the treatment of chronic kidney disease: a systematic review - PubMed

[vii] https://www.asn-online.org/policy/webdocs/26_2_9_FINAL_ASN_IOTA_Comments.pdf

Addendum: ASN Kidney Care Choices (KCC) 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 to facilitate referrals for transplant evaluation and improve dialysis facilities' ability to help referred patients complete the complex transplant evaluation process (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—particularly in the early post-transplant phase (such as 90 days). 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 general/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 potentially span the entirety of the patient journey from late-stage kidney disease onward, ASN suggests CMMI consider more discrete "phases," to involve these stakeholders along the patient journey, such as:

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