March 29, 2024

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U.S. Department of Health & Human Services
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Secretary Becerra, Administrator Brooks-LaSure, and Director Fowler:

On behalf of the kidney health professionals who comprise the membership of the American Society of Nephrology (ASN) and the Renal Physicians Association (RPA), thank you for your leadership in emphasizing prevention, coordination, and patient choice in the care of the 37 million Americans with chronic kidney disease (CKD), including the more than 800,000 with kidney failure, or End-Stage Renal Disease (ESRD). We write to voice our concern regarding proposed retrospective trend adjustments to the Comprehensive Kidney Care Contracting (CKCC) option of the Kidney Care Choices model and urge CMS to narrow the risk corridors within the model or consider other proposals to ensure continued participation in CKCC by nephrologists and nephrology practices.

CKCC is focused on overcoming siloes in kidney care to improve the health of people with advanced chronic kidney disease—efforts with important implications for advancing equity in kidney health and health care. Black Americans are over three times as likely to develop kidney failure than White Americans, while Hispanic Americans are 1.3 times more likely to do so. Black, Hispanic, and Native Americans also bear a greater burden of high blood pressure, diabetes, obesity and heart disease-- all of which increase the risk for kidney disease. As a model focused on incentivizing earlier care and support for patients with CKD (prior to the onset of kidney failure) while incentivizing smooth transitions to kidney replacement therapy for those who develop kidney failure, CKCC addresses a problem that disproportionately impacts Black, Hispanic, and Native Americans.

We believe strongly in the premise of the CKCC model, and therefore urge you to exercise your discretion to ensure that kidney care patients continue to receive the improved quality of care that CKCC participants are delivering to their patients. The application of a retroactive benchmark change—in the extreme and unforeseeable magnitude that is being proposed by CMS—will shatter nephrologist confidence in CMMI and destabilize the CKCC model.

Context

People with CKD often experience fragmented care and high-cost treatments. Many people with CKD receive limited to no education about their disease and are not made aware of their treatment options. Most people with kidney failure receive dialysis instead of a kidney transplant, a therapy that offers better outcomes for most people with kidney failure and lower cost to Medicare. Annually, Medicare spends more than $50 billion on the management of people with kidney failure, accounting for approximately seven percent of Medicare spending, on only one percent of Medicare beneficiaries.

To address these challenges and enable better outcomes for people with kidney diseases and kidney failure, nephrologists and nephrology practices enthusiastically received CMMI's Kidney Care Choices models, including the CKCC. Nephrologists caring for 40% of Medicare fee-for-service patients receiving dialysis chose to participate in the shared-savings/shared-loss CKCC model. The high participation is due to the model empowering nephrologists to drive better health outcomes for patients and reward them for reducing the avoidable emergency room visits, hospital admissions, and readmissions while increasing optimal dialysis starts and kidney transplantation. As nephrologists succeed in the model, they deliver better health outcomes to all Americans, including Black, Hispanic, and Native Americans who have been historically underserved in the U.S. health care system.

In the CKCC model, CMS provides nephrologists a "benchmark" (or baseline funding number) that is the government's projection for what an individual kidney patient's total healthcare spend is expected to be during that year. The nephrologists then make investments in services and staff to improve care and outcomes for patients during the year while measuring their work against that "benchmark." The nephrologists benefit because, after guaranteed savings to CMS and taxpayers, they capture savings from any medical spending that is lower than expected while improving quality for patients.

Concern

The COVID-19 pandemic has been especially deadly for people with kidney diseases. As you are aware, compared with the overall fee-for-service population, beneficiaries with kidney diseases had higher rates of COVID-19 diagnoses between March 2020-December 2021. People receiving dialysis had the highest rate of hospitalization from COVID-19 among fee-for-service beneficiaries, and the percentage of people who died after a diagnosis of COVID-19 was twice as high among people with kidney diseases than the general Medicare population.

Because of the devastating impact of COVID-19 on people with kidney diseases, nephrologists urged their patients to avoid infection, including staying home and limiting exposure to health care facilities whenever possible. This inadvertently resulted in a lower utilization rate of services used in the CKCC model compared against the CMS benchmark prepared before the pandemic.

CKCC participants learned recently that CMS intends to implement **retroactive reductions to the benchmark long after the conclusion of the CKCC model performance year**. These retroactive adjustments would massively reduce if not eliminate any shared savings that nephrologists thought they were signing up for and are impacted by lower care utilization rates observed when the COVID-19 pandemic was at its highest concern for people with kidney diseases. In many cases, nephrology practices will lose money because of their participation in the models.

The scale of the adjustments CMS has indicated they will make is alarming, with the 2025 Medicare Advantage Advance Rate Notice implying the retroactive change for the End Stage Renal Disease population will land at approximately eight percent for 2023, compared with approximately two percent for the general Medicare population. We are concerned that nephrology practices, once aware of this change, will withdraw from participation in the model (and will likely be disinclined to participate in future models).

Nephrologists are delivering excellent outcomes for Medicare beneficiaries in the model, it is important that people with kidney diseases continue to benefit from incentives that promote more coordinated care, reduced hospitalization, and access to transplantation. We are particularly concerned about the health equity implications of destabilizing a model that improves care for people with kidney diseases and kidney failure, diseases that are disproportionately experienced by Black, Hispanic, and Native Americans.

While CMS has not released official model results yet, we observe that nephrologists in the model have made progress on optimal starts on dialysis, depression screening (PHQ-9) completion, and patient activation measure (PAM) change score. These positive outcomes are associated with improved health, aligning with more days that patients spend healthy and at home while simultaneously reducing taxpayer spend on avoidable emergency department visits and hospital admissions. Unfortunately, CKCC participants cannot continue the investment necessary to deliver this impact for patients and risk large benchmark changes after they have already provided care. We have heard from practices that they intend to drop out of the model in advance of the financial accountability deadline on April 30, 2024, absent changes. Ultimately, this retroactive change in the CKCC benchmark will hurt people with CKD.

We understand CMS is aware of these concerns and appreciate CMS acknowledging retroactive changes may be unpredictable. We also appreciate the commitment CMS has made to limit retroactive changes starting in 2024, and in extending the deadline for financial accountability for 2024 till the end of April to allow model participants to gain more information prior to the deadline to withdraw from the model. We hope to continue working with CMS to find a path forward that will ensure nephrology practices are able to continue their participation in this transformative model.

<u>Solution</u>

We reiterate ASN and RPA's request that CMS apply narrower risk corridors in CKCC from the start of the model to limit the maximum exposure any participant has to a positive or negative two percent of benchmark. Narrower corridors will limit risk for participants in a budget neutral manner, as they will apply year-over-year, regardless of how the RTA trends. When spending on a typical ESRD patient reaches $100,000, it is simply too high a figure for participants to face the uncertainty of seven to eight percent benchmark adjustments long after they have financially planned for previously determined risk.

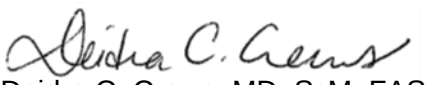
In addition, we recommend the following changes to stabilize the model and encourage continued participation for the benefit of kidney patients:

- **Adjust the Discount.** REACH ACO has a maximum 3.5 percent discount for global while CKCC has a six percent discount. Since each percentage on an ESRD patient equates to a higher savings figure for the taxpayer, CKCC should have a lower discount than REACH ACO rather than a higher discount. As the CKCC program serves a disproportionately high percentage of minoritized Americans, we believe that attention should be provided to the discount rate to ensure racial health disparities are reduced, not widened. Our recommendation is that CMS should shift the CKCC discount to a maximum of two percent to enable sustained model participation and ensure kidney patients are not disadvantaged.
- **Reflect Transplant Status Accurately.** Patients with older transplants that are beyond the twelve-month lookback window are not removed due to their transplants but may incur higher costs. To correct, CKCC should reflect transplant status for patients who are beyond the 12 months look back with a transplant status adjustment tailored based on the observed incremental cost of these patients.
- **Update CKD Upward Adjustment.** Currently there is a CKD upward adjustment for patients who do not progress to ESRD for more than two years. However, the CKD versus ESRD benchmarks appear to be misaligned, resulting in a financially unfavorable status of remaining 'CKD.' To correct this, CKCC should increase the CKD upward adjustment from one percent to five percent of benchmark to better incentivize CKCCs to reduce the progression to kidney failure.
- **Transform Quarterly Capitated Payment** into to a PCC similar type mechanism with a four percent enhanced for the global TCOC track.

These changes would improve predictability for nephrologists to provide better care to their patients. ASN and RPA look forward to continuing dialogue with you to ensure that people with kidney diseases continue to benefit from care that emphasizes care coordination, delayed progression and reduced hospitalization, and access to transplant.

Again, thank you for your consideration on this matter and for your leadership in improving the care of the millions of Americans living with kidney diseases. ASN and RPA strongly believe in the CKCC model and the opportunity it provides nephrologists to improve care for patients. To discuss this letter, our organizations' support of the CKCC model, or our efforts to achieve kidney health, please do not hesitate to contact David White, ASN Quality and Regulatory Affairs Officer at dwhite@asn-online.org or 202-618-640-4635 or Rob Blaser, RPA Director of Public Policy, at 301-468-3515 or rblaser@renalmd.org.

Sincerely,



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About ASN

Since 1966, ASN has been leading the fight to prevent, treat, and cure kidney diseases throughout the world by educating health professionals and scientists, advancing research and innovation, communicating new knowledge and advocating for the highest quality care for patients. ASN has nearly 22,000 members representing 141 countries. For more information, visit www.asn-online.org and follow us on Facebook, X, LinkedIn, and Instagram.

About RPA

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with kidney disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with kidney disease.