



January 30, 2026

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

200 Independence Avenue SW

Washington, D.C. 20201

Sent Via Electronic Mail: PTAC@HHS.gov

RE: Improving Multi-Payer Alignment in Value-Based Care- Request for Input (RFI)

Dear Physician-Focused Payment Model Technical Advisory Committee,

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 the opportunity to provide comments in response to your public comment period with reference to 'Improving Multi-Payer Alignment in Value-Based Care' Request for Input (RFI).

The nephrology community has significant experience in value-based care arrangements. The first specialty-specific Accountable Care Organization (ACO) was created for dialysis patients through the ESRD Seamless Care Organizations (ESCOs) in 2015ⁱ. Since that time, the nephrology community has gained extensive experience with both voluntary and mandatory federal models as part of the Trump Administration's Advancing American Kidney Health Initiativeⁱⁱ through the Center for Medicare and Medicaid Innovation (CMMI), including the Kidney Care Choices (KCC), End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model and Increasing Organ Transplant Access (IOTA) models. These experiences have generated important insights to inform model design and implementation. Below are several points ASN would like to share regarding each of the seven questions that you have posed.

1. What are approaches to multi-payer alignment that CMS and other parties could use to test and implement multi-payer models in value-based care?

ASN encourages PTAC to use existing tools developed by CMMI that address core elements of value-based care. These tools include performance measurement, payment methodologies, risk adjustment, and data sharing. ASN encourages PTAC to build on this foundation by considering shared performance measures, quality metrics, and learning collaboratives that support multi-payer alignment.

ASN also encourages PTAC to leverage CMMI-supported State-Based Total Cost of Care Models. These models draw on the experience of states that have served as

value-based care hubs and coordinated participation across multiple payers. This experience offers practical lessons for aligning incentives and reducing fragmentation.

In nephrology, ASN encourages PTAC to consider approaches that build on CMMI's KCC model and align with private insurer Value-Based Insurance Design (VBID) initiatives. By using the Comprehensive Kidney Care Contracting (CKCC) framework within the KCC model as a baseline, PTAC could recommend strategies that encourage commercial payers to adopt comparable capitated payment structures for patients with chronic kidney disease (CKD) stages 4 and 5. Such alignment would reduce administrative burden for nephrology practices that currently navigate differing quality measures and payment requirements across Medicare and commercial plans, while supporting a consistent focus on home dialysis and transplant readiness across a provider's full patient panel.

Finally, ASN encourages CMMI to continue to explore value-based care impacts for Medicare Advantage beneficiaries, now representing the majority of patients with kidney failure requiring dialysis. There are limited data available within United States Renal Data System related to comorbid conditions and clinical outcomes for Medicare Advantage beneficiaries as compared to traditional Medicare beneficiaries. Ensuring data transparency will allow for effective comparisons and iteration of models.

2. What are lessons learned from state value-based care models that have implemented multi-payer alignment?

ASN encourages PTAC to consider lessons learned from state value-based care models that have implemented multi-payer alignment. Several states have served as central coordinators by improving payer alignment, reducing administrative burden, and supporting the adoption of value-based arrangements.

State models, such as those in Maryland and Vermont, have demonstrated that multi-payer alignment requires a neutral convener to facilitate trust between competing insurers. A key lesson learned from the nephrology community is that state-led approaches may lack the disease-specific focus needed for high-cost, low-volume chronic conditions. Experience suggests that mandatory participation by major payers may be necessary to achieve the patient scale required for practices to invest in care coordination infrastructure. In kidney care, state or national models should consider successful lessons learned from ESCOs, which demonstrated that focused, integrated, and tailored care for a defined patient population can significantly reduce hospitalizations and reduce associated costs more effectively than broad all-payer primary care modelsⁱⁱⁱ.

ASN encourages PTAC to support the use of Pre-Implementation Periods that include pre-payment mechanisms of sufficient length to provide participants with the necessary time and financial resources to establish the infrastructure needed to successfully implement the model^{iv}.

ASN also emphasizes the importance of health equity in multi-payer value-based care models. PTAC should consider how performance metrics can be linked to social determinants of health (SDOH)-related benchmarks and supported by risk adjustment. This is essential to ensure that centers serving beneficiaries with higher social risk are not disadvantaged.

The importance of this approach was demonstrated in the mandatory ETC Model. Separate scoring strata were created for facilities in which 50 percent or more of patients are dually enrolled in Medicare and Medicaid or receive Low-Income Subsidies. The ETC Model marked the first time in CMS payment model history that performance adjustments were explicitly used to address differences driven by socioeconomic factors (for example, the lower utilization of home dialysis among Medicare beneficiaries with unstable housing). Following the ETC Model, CMS went on to incorporate payment and benchmark adjustments based on Medicare-Medicaid dual eligibility status and area deprivation indices in several other models^v.

3. What are effective strategies that have been used in practice to align financial incentives, benchmarking, attribution, and risk-adjustment methods within and across multiple payers?

ASN believes effective alignment requires a shift from retroactive reconciliation to prospective, risk-adjusted payments. For example, in nephrology, financial incentives must be aligned to reward “optimal starts,” defined as initiating dialysis with a permanent access or through home modalities. Upfront resourcing is particularly relevant to nephrology given the need to invest in structural changes to care models (e.g. care coordination, implementation of educational programming etc). While the ETC model attempted to align incentives through mandatory payment adjustments, it lacked the sophisticated risk adjustment necessary for medically complex and dual-eligible patients. Lessons from the 2026 evaluations suggest that benchmarking should be based on regional historical spending rather than national averages in order to better account for local factors, including poverty and access to care. Alignment is most effective when attribution is patient-centered, allowing the nephrologist to serve as the principal care provider for the duration of the kidney disease journey among individuals with advanced kidney disease.

ASN also recommends the use of uniform and transparent benchmarking formulas. The frameworks of existing models, such as the Medicare Shared Savings Program (MSSP) and the Comprehensive Kidney Care Contracting (CKCC) options within the KCC Model, provide relevant examples on how this can be achieved. Adopting similar, transparent, shared attribution rules would help align clinicians and reduce administrative variation across models. Finally, ASN believes CMS should use a standardized risk adjustment approach with appropriate caps, applying CMS’s standard methodology consistently across payers.

4. What methods have been effectively used to standardize performance measures and reporting across multiple payers?

ASN believes that standardization can be best achieved through the adoption of a “Kidney-Specific Core Set” of measures agreed upon by CMS and private payers. The nephrology community has experienced fragmented reporting requirements that have led to metric fatigue and a lack of parsimonious, specific metrics. To address this challenge, future models should leverage the KCC Model’s focus on transplant waitlisting and home dialysis rates as quality indicators. These measures, when well-constructed, reflect outcomes that matter most in terms of opportunities for optimal care delivery, improved quality of life, and lower costs to both patients and health systems. Utilizing a single reporting portal and standardized EHR data pulls would allow providers to report once for multiple payers, reducing administrative burden. This approach would also help prevent the “failure of focus” observed in earlier models, where clinicians were distracted by conflicting clinical targets across different insurance providers.

In addition, core performance and quality measures should be clearly defined and designed for application across payers. The use of shared data platforms and standardized reporting templates should be encouraged to further streamline reporting and promote consistency. Finally, SDOH and economic indicators should be incorporated into standardization and/or risk adjustment where able and where appropriate.

5. How are antitrust regulations and the use of safe harbor waivers navigated to effectively implement multi-payer alignment?

CMS should host cross-payer discussions and pattern safe harbor structures on CMMI models. This approach would allow for alignment on quality metrics, benchmarks, and reporting requirements without violating antitrust regulations. In addition, CMS should be permitted to allow shared learning systems to further support collaboration and dissemination of best practices. Kidney care, particularly dialysis, is exceptionally consolidated; it is critical to allow entities to engage fully in models while also not promoting further consolidation.

6. What are examples of approaches that have been successfully used to overcome competitive market dynamics and promote collaboration among payers?

The Medicare ESCO Model demonstrated that when providers and payers operate within a shared-savings framework, the competitive incentive to “cherry-pick” healthier patients is mitigated by the financial rewards associated with effectively managing the most complex and highest-cost patients. Similarly, the CMMI CKCC model has demonstrated meaningful improvements in year one, including a 32% increase in home dialysis rates and a 16% increase in “optimal” starts for Americans living with kidney

failure (transplant and home dialysis), reflecting the impact of a CMS-led capitated, incentive-based model.^{vi}

With respect to a true collaborative model across multiple payor types, AHEAD (Achieving Healthcare Efficiency through Accountable Design)^{vii} is a voluntary state total cost of care (TCOC)^{viii} initiative involving six states: Maryland, Connecticut, Hawaii, Vermont, Rhode Island, and New York. The model aims to manage care across Medicare, Medicaid, and commercial payors. While still in its early stages, AHEAD offers an opportunity to learn from a collaboration across payors.

7. What are examples of effective approaches used to overcome other factors that may influence collaboration and engagement among payers in multi-payer alignment initiatives (e.g., a desire for product differentiation from competitors, elements of payment design considered proprietary)?

Establishing certain shared measurement with standard and clearly defined measures can support alignment across payers. In addition, shared governance structures should be encouraged to facilitate collaboration and coordinated decision-making. Finally, simplified and aligned reporting and submission that aims to reduce burden for provider groups is critical.

ASN offers additional observations that were not explicitly requested in the RFI, but that are informed by experience in existing kidney models and are critical to achieving the RFI's stated goals.

- ***Care Coordination and Patient Selection:*** Physician-focused payment models must be structured to prioritize robust care coordination services for all patients, particularly those in underserved areas. Unlike traditional Fee-for-Service structures that often disadvantage complex patients by failing to support non-clinical coordination, new models should utilize geographic indices of social risk to adjust payment rates. This ensures that physicians are adequately resourced to identify social needs and connect patients with community-based services that can help improve patient outcomes.
- ***Financial Methodology and Risk Adjustment:*** To maximize participation and ensure sustainability, payment models should incorporate risk-adjusted target costs and provide both upside and downside risk options. It is critical to include protections such as risk corridors and stop-loss provisions to shield practices from financial harm caused by factors beyond their control, such as significant social drivers of health. These risk corridors and stop-loss provisions are particularly important in kidney care, where there are relatively small numbers of individuals with advanced kidney disease who are at very high risk of adverse medical events, such that a handful of catastrophic events can move an otherwise successful provider to failure.

- **Specialty Integration and Accountability:** Future models should encourage collaborative, team-based care that aligns primary care and specialty physicians. By utilizing enhanced condition-based payments, specialists can focus on accurate diagnosis and long-term patient management rather than volume-driven procedures. This whole-person approach is essential for managing chronic conditions effectively and reducing the total cost of care while improving patient and caregiver satisfaction.

ASN also offers an overview of the successes and failures of the value-based care models in the kidney space:

1. ESRD Treatment Choices (ETC) Model

Dates: January 1, 2021 – December 31, 2025 (terminated early)

Limitations: The ETC model, a mandatory program intended to increase home dialysis and transplant waitlisting through payment adjustments, has been deemed largely unsuccessful in meeting its primary goals. Evaluation reports through 2025 showed no statistically significant impact on home dialysis modality use or transplant waitlisting.

Current Status: Due to its limited results, CMMI finalized the termination of the ETC Model as of December 31, 2025.

2. ESRD Seamless Care Organization (ESCO) Model

Dates: October 15 – March 31, 2021

Successes: As one of the first major kidney care demonstrations, the ESCO model proved that a coordinated care design focused on dialysis could successfully reduce Medicare spending and hospital utilization. Relative to the comparison group, CEC beneficiaries had 5.01 fewer hospitalizations per 1,000 beneficiaries per month (95% CI, -8.45 to -1.56; P = .004), experienced fewer catheter placements (a 0.78 percentage point decrease for beneficiaries using a catheter as vascular access for more than 90 days; 95% CI, -1.36 to -0.19; P = .01), and were 0.11 percentage points less likely to be hospitalized for ESRD complications in a given month (95% CI, -0.20 to -0.02; P = .01). It also improved readmission rates and dialysis adherence^{ix}.

Limitations: While ESCO was effective for patients already on dialysis, it lacked the "upstream" focus on CKD stages 4 and 5 that the newer CKCC models aimed to address to prevent progression to kidney failure altogether, or smooth transition to end stage care.

3. Kidney Care Choices Model (KCC)

Dates: January 1, 2022- December 21, 2027 (model extended)

Successes: The KCC model has successfully increased the proportion of patients receiving home dialysis training and increased "Optimal ESRD Starts" (planned transitions to dialysis) by 16%.

Limitations: Despite quality gains, the model resulted in significant net losses to Medicare (approx. \$304 million in 2023). Consequently, for 2026, CMMI has reduced the CKD Quarterly Capitation Payment by 50% and eliminated the \$15,000 kidney transplant bonus to improve fiscal sustainability. The Kidney Care First (KCF) option was also terminated early, effective December 31, 2025. ASN has voiced the importance of maintaining financial resourcing to enable coordination of care, educational programming, structural changes to dialysis initiation processes etc. We have concerns about the long-term health of the model without recognizing the financial support required to improve clinical outcomes, which will stem long-term costs.

Conclusion

ASN emphasizes that, for a PFPM to succeed in 2026 and beyond, it must balance the expenditure reductions mandated by the KCC updates with the care coordination successes demonstrated under the ESCO model. Strong consideration should also be given to "upstream" models that address chronic kidney disease or the risk of CKD earlier in the disease course, with the goal of slowing or preventing progression to kidney failure. Such progression is costly not only from a financial perspective, but also in terms of quality of life and survival for patients. Aligning payment models with early intervention, coordinated care, and meaningful outcomes will be essential to achieving sustainable improvements for patients and the health care system. Lastly, it is critical that any future model related to kidney disease examines long-term cost savings by slowing the rate of kidney disease progression, avoiding crash starts into dialysis, and fostering transplantation. Partnering with organizations like ASN is crucial to ensure there is frontline provider input, as well as experiential perspective on feasibility and potential impact on cost and outcomes. To discuss this letter further, please contact Lauren Ahearn, ASN Policy and Government and Affairs Coordinator, at lahearn@asn-online.org.

Sincerely,



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President

ⁱ [Comprehensive ESRD Care Model | CMS](#)

ⁱⁱ [AdvancingAmericanKidneyHealth.pdf](#)

ⁱⁱⁱ <https://www.healio.com/news/nephrology/20190911/esco-demonstration-shows-reduction-in-hospitalizations-more-dialysis-sessions>

^{iv} <https://www.ncbi.nlm.nih.gov/books/NBK566221/>

^v <https://www.healthaffairs.org/content/forefront/advancing-health-equity-through-value-based-care-cms-innovation-center-update>

^{vi} [kcc_ar1_executive_summary_508_updated_10.25.24.pdf](#)

^{vii} <https://www.cms.gov/priorities/innovation/innovation-models/ahead>

^{viii} <https://www.cms.gov/priorities/innovation/key-concepts/total-cost-care-and-hospital-global-budgets>

^{ix} <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2763414>