



PRESIDENT
Gary G Singer, MD, FACP
Saint Peters, Missouri

PRESIDENT-ELECT
Alexander S Liang, MD
Dallas, Texas

SECRETARY/TREASURER
Katherine W Kwon, MD, FASN
Saint Joseph, Michigan

PAST PRESIDENT
Keith A Bellovich, DO
Detroit, Michigan

COUNSELOR
Jeffrey A Perlmutter, MD
Rockville, Maryland

BOARD OF DIRECTORS
Samaya J Anumudu, MD
Spring, Texas

Brendan T Bowman, MD
Charlottesville, Virginia

Arvind Garg, MD
La Crosse, Wisconsin

Virginia Irwin-Scott, DO, MBA,
CPE, FASN, FACOI
Miami, Florida

Nishant B Jalandhara, MD
Colleyville, Texas

Evan R Norfolk, MD
Danville, Pennsylvania

Rajiv D Poduval, MD
Phoenix, Arizona

Anika Porter, MEd
Houston, Texas

Khalil Rahman, MD, MBA
Lexington, Kentucky

Laura Rankin, MD
Oklahoma City, Oklahoma

S Ted Shaikewitz, MD
Durham, North Carolina

Sarah Swartz, MD
Houston, Texas

Manish M Tanna, MD
Oak Brook, Illinois

EXECUTIVE DIRECTOR
Adonia Calhoun Groom, CAE, CMP
Rockville, Maryland

May 12, 2025

Tom Duvall
Division Director
Division of Special Populations and Projects
Seamless Care Models Group
CMS Innovation Center
WB-06-05
7500 Security Boulevard
Baltimore, MD 21244-8013

Dear Mr. Duvall,

The Renal Physicians Association (RPA) has been supporting nephrology practices for over 50 years and represents nephrologists with significant leadership experience in Value Based Care (VBC). As a longstanding advocate of VBC, we write to express our strong support for continuing the Comprehensive Kidney Care Contracting (CKCC) model. We appreciate the opportunity to provide suggestions for refining the model as it evolves into its second generation. We are grateful for the opportunity to participate in VBC models designed to improve the lives of patients with kidney disease, and we respectfully offer the following refinements to ensure the program's continued success:

1. Program Continuity Through 2032

Transitioning to VBC required substantial investment in infrastructure, capital allocation and a change in the operational culture of nephrology practices. A multi-year strategy was essential to generate the necessary resources, establish care coordination services, and develop patient support programs required to succeed in VBC. Long-term program stability is critical to justify a practice's investment in these endeavors. To this end, RPA urges CMMI to commit to continuing the CKCC model as a voluntary program through at least 2032.

2. Simpler Risk Adjustment Processes

Our patients vary greatly in their comorbidities and thus their expected cost of care. The current Medicare-Advantage (MA)

based process for setting a baseline for the determination of savings is burdensome and time consuming, leading to higher benchmark costs that do not translate into improved patient care. We urge CMMI to develop a more accurate, transparent, and automated risk adjustment method to assess and update patient comorbidities.

3. Expand Access to More Nephrologists

Most nephrology practices do not participate in the CKCC program due to their small size and the prohibitive financial guarantees required. We understand that programs need sufficient numbers of patients to have statistically meaningful outcomes. Practices should be allowed to pool their results across geographic regions to achieve statistical validity. The large financial guarantees required to participate are also untenable to nephrology practices. The RPA would like to work with CMMI to create a process where nephrology practices can participate in shared savings programs with lower capital requirements, enabling broader participation.

4. Faster Data Reporting and Payment

Timely access to actionable data is essential for practices to respond proactively to patient needs and manage care more effectively. Metrics based on claims data are inherently delayed such that practices are often unaware of how they are performing until it is too late to intervene and improve, if performing poorly. CMMI should explore ways to pre-analyze or otherwise organize data for participating entities to the extent possible, as this would relieve that burden from participants and lower the bar for smaller practices to participate. Regarding reimbursement, faster payment of shared savings is necessary to better align financial operations with care delivery expenses. CMMI should develop an adjudication process to credit practices when data or payments are delayed beyond program timeliness.

5. Improved and Timely Patient Attribution

Timely and accurate patient attribution is vital. Practices must know early in the performance year which patients they are responsible for, allowing them to deliver coordinated care and meet performance goals. Alignment should be stable throughout the year as long as patients continue receiving care from program participants.

6. Stable and Transparent Benchmarks and Metrics

In order to manage performance effectively, practices require benchmark data that are both stable and transparent throughout the program. The metrics should be well-studied, actionable, and reportable to reduce the burden on practices to participate. Significant changes made after the model year has concluded undermines the confidence in the program. The use of metrics that lack transparency in calculation prevents practices from gauging their progress and intervening in real-time when they can make a difference. The retrospective trend adjustment, while transparent, was flawed in its design and failed to account for the impact of COVID in healthcare utilization. This resulted in massive losses for those participating in the CKCC program and forced a meaningful number of practices to leave the program. A reliable, transparent, and accurate cost trend methodology is urgently needed.

7. Continuation of the Bonus for Transplantation

The transplant bonus has been a significant and meaningful incentive through the development of infrastructure that helps practices improve patient outcomes. RPA strongly supports the continuation of this bonus in the second generation of CKCC to support ongoing efforts to increase the rates of both transplantation and home dialysis as the incident dialysis modality of choice among our patients.

8. Flexibility in Patient Benefits and Incentives

We encourage CMMI to allow for greater creativity and flexibility in offering patient benefits and incentives by providing broader Stark protections. Tailoring approaches to meet patients' unique needs is critical to achieving the program's goals of improved health outcomes and overall cost savings. Every patient is unique, frequently requiring creative solutions to optimize outcomes, particularly those with adverse social determinants of health indices. Restrictions on transportation to essential services should be removed, and reasonable inducements to attend education sessions or to reward treatment compliance allowed. Additionally, the administration of these beneficiary enhancements needs to be streamlined to minimize the overhead costs for the practices.

9. Incentivize Collaboration with other Healthcare Entities and Providers

Our patients are complex and require coordinated care across multiple providers and systems. However, many practices encounter barriers to collaboration due to Stark restrictions and competing program requirements. We recommend CMMI support creative solutions that foster more collaboration and communication with these organizations. Additional support for advanced care planning and active medical care without dialysis (conservative care) will also help to optimize outcomes in this challenging population.

We believe that by addressing these key areas, the next generation of CKCC can build on its early successes and drive further improvements in kidney care. RPA values CMMI's commitment to patient-centered innovation and looks forward to continued collaboration. Questions regarding this correspondence may be directed to RPA's Director of Public Policy, Rob Blaser, at 301-468-3515 or by email at rblaser@renalmd.org.

Thank you for your consideration.

Sincerely,



Gary G. Singer, MD, FACP
RPA President



Adonia Calhoun Groom, CAE, CMP
RPA Executive Director

CC: Robert Blaser, RPA Director of Public Policy