A Vision for Value-Based Approaches to Early Kidney Disease Prevention and Management

COALITION FOR KIDNEY HEALTH

Fall 2025

Executive Summary

This white paper makes recommendations for actions the Center for Medicare and Medicaid Innovation (CMMI) should take to expand its focus on early detection and management of chronic kidney disease (CKD). These recommendations:

- Are practical and tangible, building on work the Center's Groups and Divisions are already advancing.
- Include a mix of model design features that could be adopted in existing models and models under development, as well as new concepts and activities the Innovation Center could lead under its authorities but independent of a specific model framework (see Innovation Center tactics in Table 1).
- Are aligned with the Center's 2025 Strategy to Make America Healthy Again (MAHA) and its vision for promoting multipayer alignment. Consistent with calls for a "multidisciplinary, patient-centered approach" for improving CKD care focused on improving prevention, screening, risk stratification, medication access and adherence, education, primary care delivery and optimization of technology, as recently articulated by the National Committee for Quality Assurance (NCQA), among other stakeholders.[1]
- Emphasize the need to focus on integrated care models that address the intersection of kidney disease, cardiovascular diseases, and metabolic conditions, acting on the unique opportunity to drive down spending in this disproportionately expensive population.
- Are categorized by policy goals and tactics under the overarching MAHA strategy, as described in Table 1.

Table 1. **Tactical Recommendations Correspond to CKD Policy Goals Under the MAHA Strategy**

Overarching Strategy	Early Chronic Kidney Disease Policy Goals	Innovation Center Tactics
Making America Healthy Again by reducing the burden of chronic kidney disease on the American people	Kidney disease prevention through early, comprehensive screening	**Benefit Enhancements (BEs) and Beneficiary Engagement Incentives (BEIs)** (e.g., waivers, model requirements)
	Patient activation and clinician education	**Multipayer Alignment** (e.g., model incentives, payor convenings)

Table 1. **Tactical Recommendations Correspond to CKD Policy Goals Under the MAHA Strategy**

Overarching Strategy	Early Chronic Kidney Disease Policy Goals	Innovation Center Tactics
Making America Healthy Again by reducing the burden of chronic kidney disease on the American people	Reduce disability and improve quality of life	**Accountable Care** (e.g., incorporating specific kidney disease policies and incentives in ACO designs
	Improved coordination between primary and specialty care	**Population Health Approaches**
	Increase disease management support	**Quality Measurement**
	Delay kidney disease progression	**Facilitating Education** (e.g., advance vision and increase stakeholder buy-in through HCPLAN)
	Close care gaps for vulnerable populations	

Making America Healthy Again

President Trump, Secretary Robert Kennedy Jr., CMS Administrator Dr. Oz, and Innovation Center Director Abe Sutton are working to apply the precepts of the Make America Healthy Again (MAHA) movement to our healthcare system, focusing on preventing chronic disease and reducing its burden on the American people.[2] The Innovation Center's 2025 strategy to Make America Healthy Again, built on a foundation of protecting the taxpayer's investment in innovation, is recentering the Innovation Center's efforts on three pillars of promoting evidence-based prevention, patient empowerment, and driving choice and competition.

Chronic kidney disease (CKD) is an underacknowledged public health crisis leading to disability, mortality, reduced quality of life, and drastic health expenditures for nearly fifteen percent of American adults.[3] We are in a time of unprecedented opportunity to reduce the burden of kidney disease and kidney failure on the American people. Over the past decade, the toolbox of options to prevent kidney disease, slow its progression, and reduce complications and comorbidities has entered its golden age. Homing in on the kidney disease crisis by focusing on kidney health, prevention of kidney disease, and slowing or stopping kidney disease progression must be a key component of the MAHA framework (Figure 1).

Figure 1. **Investments in CKD Align with the Pillars of the Center's MAHA Strategy**

Protecting the American Taxpayer

Medicare spends over $50 billion dollars on kidney failure, an expenditure that is expected to only grow

Investment is needed in prevention and early treatment to reduce federal spending on kidney failure.

Promote Evidence-Based Prevention

Kidney disease can be prevented through low-cost, guideline-directed tests including blood and urine analysis.

Clinical practice guidelines supports deploying a range of tools to prevent and treat kidney disease.

Empower People to Achieve Health Goals

90% of people with kidney disease don't know they have it.

The first steps are empowering people with information about kidney health and putting tools into their hands to protect it.

Drive Choice and Competition

80% of dialysis treatments are provided by two dialysis providers.

Preventing the need for dialysis is the fastest and simplest way to shift this dynamic.

Driving Towards Transformation, Protecting the Taxpayer

The Innovation Center is a key piece of the puzzle transforming the "what" of catalyzing America's commitment to prevention and treatment of chronic disease into the "how." **Stated differently, the Innovation Center is transforming vision into action**. Committing to early detection and management of kidney disease is a commonsense approach to reducing the dynamic in which a small population of complex, chronically ill Medicare beneficiaries such as those with kidney failure generate disproportionate program spending.[4] A growing body of evidence suggests that screening for kidney disease is cost effective and that population health approaches to CKD management can reduce utilization and selected expenses.[5] [6]

The Innovation Center has a robust pipeline of models in the kidney space. The Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model, Kidney Care Choices (KCC) Model, and Increasing Organ Transplant Access (IOTA) Model have made promising strides towards improving beneficiary choice of treatment modality for kidney failure, but Medicare savings have been slow to materialize from the current kidney model portfolio. To generate savings and achieve the goals of MAHA, the Innovation Center must focus on preventive medicine for kidney patients through the available levers:

Benefit Enhancement (BEs), Beneficiary Engagement Incentives (BEIs), and Other Model Waivers

Embed CKD detection, prevention, and care management into the portfolio through fraud and abuse flexibilities and payment waivers.

Multipayer Alignment

Leverage the Learning and Action Network (LAN) to bring payers together to discuss opportunities for better managing kidney disease and to brainstorm incentives that would drive investment in prevention and early intervention in CKD, leverage those learnings to facilitate plan adoption of CMMI model concepts through multi-payer alignment, and consider other approaches to provide incentives for health plans to increase focus on preventive medicine, including flexibilities for MA plans.

Performance-Based Payment

Incentivizing upstream care through performance-based payment policies that incorporate quality measures driving improvements in kidney disease screening, such as Kidney Health Evaluation for Adults with Diabetes (KED), and those empowering and activating patients such as the Patient Activation Measure (PAM).

Population Health

Testing proven population health approaches to kidney disease detection and management, for example, CKDintercept, through state models, health plan incentives, and—as noted above--multipayer engagement through the LAN.[7] [8]

Facilitating Activation and Education

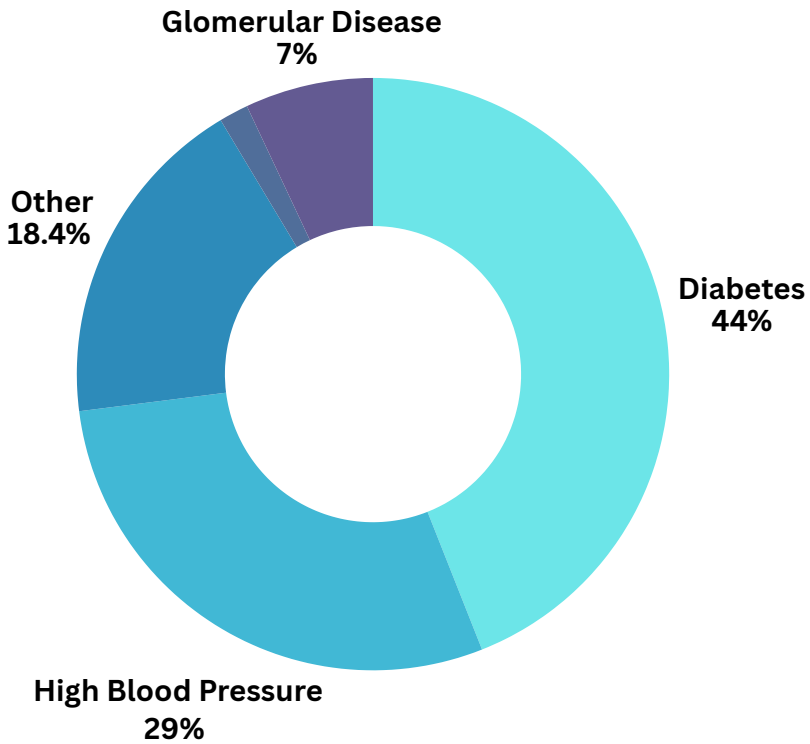
Activities outside a specific model framework that convene stakeholders and disseminate vision and learning

Kidney Disease Background

CKD, the progressive loss of kidney function over time, is common and burdensome. No chronic disease impacting Americans is so prevalent and so underrecognized as CKD. 35.5 million U.S. adults have kidney disease and over 90% are unaware, even as kidney disease is the eighth leading cause of death in the United States, causing more deaths than common cancers such as breast and prostate cancer.[9] CKD has few signs or symptoms until it is advanced. As a result, 1 in 3 U.S. adults with advanced disease do not know they have it.[10]

Diabetes and hypertension are the leading causes of CKD, but CKD can also be caused by inherited conditions like polycystic kidney disease (PKD), glomerular diseases, and autoimmune conditions like lupus, among other conditions and circumstances (Figure 2).[11]

Figure 2. *Causes of Chronic Kidney Disease*



Many of these conditions are rare diseases, further complicating efforts for patients to secure diagnoses and access to care, but in total they drive a significant share of the burden caused by CKD (e.g., glomerular disease is mostly caused by rare diseases but in total accounts for at least 10–15 percent of kidney failure).[12] CKD is closely related to a range of comorbidities, especially to cardiovascular disease, which lead to high morbidity and mortality.[13] People with CKD who survive its comorbidities may eventually lose all kidney function, resulting in end-stage renal disease (ESRD). Once someone has reached kidney failure, he or she depends on dialysis or a kidney transplant to survive.

CKD is marked by missed opportunities to close gaps in care, a point emphasized by NCQA in its accounting of challenges and opportunities related to preventing CKD, identifying people with CKD, CKD management and monitoring, and the role of CKD in the cardiovascular-kidney-metabolic (CKM) syndrome model (See "Intersection of Kidney Disease and Heart Disease." Across stakeholders, there is clear interest in novel approaches to close gaps and improve the health of the nation.

The consequences of underdiagnosed and undermanaged CKD are extraordinary. The 15 percent of aged Medicare beneficiaries with CKD account for more than a quarter of total fee-for-service Medicare spending ($86.4 billion).[14] Beneficiaries with ESRD account for more than another $50 billion annually.[15] As more Medicare beneficiaries with kidney disease migrate to Medicare Advantage (MA), MA spending on kidney disease is rapidly increasing. In 2021, Medicare Advantage spending on ESRD increased by 46.4% in one year.[16]

For the Medicare program alone, the implications of kidney disease are extreme given that by 2060, the number of people age 85 years and older is projected to triple from its current estimate of 6.7 million to 19.0 million.[17] Rare kidney diseases can be especially costly because they can cause ESRD at younger ages, representing a disproportionate share of children and adolescents with ESRD. [18] In addition, rare kidney diseases like some glomerular diseases can recur after kidney transplant, and are the third leading cause of dysfunction of the transplanted kidney, demonstrating the special need to slow kidney disease progression for this population.[19]

Intersection of Kidney Disease and Heart Disease

The association of dysfunction between cardiovascular and kidney function is known as cardiorenal syndrome. Hypertension is a leading cause of kidney disease. As hypertension damages the cardiovascular system by enlarging and weakening the heart and microvasculature of the heart and kidneys, it creates a positive feedback loop known as cardiorenal syndrome. Damage to the kidney and heart are further exacerbated by the buildup of toxins in the blood as kidney function further deteriorates, resulting in heart attacks and strokes. Stated differently, in cases of cardiorenal syndrome, dysfunction in either the heart or the kidneys is associated with dysfunction in the other organ.[20] The most common cardiovascular conditions in CKD are heart failure (HF), coronary artery diseases (CAD), heart attacks and stroke. All patients with CKD experience a higher risk of cardiovascular events with late-stage CKD (stages 4-5) experiencing a much higher risk than early-stage CKD (stages 1-3).[21] People with kidney disease are more likely to die of cardiovascular disease than to progress to ESRD.

Albuminuria, an established biomarker of the progression of chronic kidney disease, is also recognized as a biomarker for the risk of cardiovascular disease. Elevated urinary albumin excretion indicates kidney damage and systemic vascular disease, including myocardial capillary disease and arterial stiffness. Albuminuria is associated with an increased risk of coronary artery disease, stroke, heart failure, arrhythmias, and microvascular disease. There are now several therapeutic agents that can lead to albuminuria lowering and a reduction in cardiovascular risk. However, screening for albuminuria is still low.

Cardiovascular disease, kidney disease, and metabolic conditions like diabetes and overweight frequently occur together and are categorized as cardiovascular-kidney-metabolic syndrome (CKM).[22] The CKM model helps to explain the relation between the cardiovascular system, metabolic risk factors, and chronic kidney disease. Taken together, 1 in 3 US adults have three or more risk factors leading to CKM syndrome, emphasizing the value of addressing CKM as a means of Making America Healthy Again.[23]

Medicare data confirm the magnitude of the opportunity to reduce program expenditures and reduce disability while improving quality of life by intervening early with a holistic approach to kidney disease, cardiovascular disease, and metabolic conditions. In 2022, approximately 59 percent of beneficiaries with CKD also had diabetes, heart failure, or both diabetes and heart failure. The subset with at least one of these two major comorbidities represented 69% of the costs of individuals with CKD. Per-patient per-year spending for beneficiaries with CKD, heart failure, and diabetes across Parts A, B, and D is nearly $50,000 compared with $13,968 for beneficiaries with no CKD and $20,212 for beneficiaries with CKD only.[24]

The treatment of many cases of CKD where there is underlying interaction between organ systems now exceeds the narrow lens on management of CKD in the primary care setting with a handoff to a nephrologist after a period of co-management. The Innovation Center should consider using its authorities to upstream models that leverage proven tools to reduce cardiovascular risk associated with kidney disease, a major driver of inpatient utilization and spending in this population. According to the US Renal Data System, beneficiaries with CKD, diabetes, and cardiovascular disease had 255% higher demographic adjusted all-cause hospitalization rate than beneficiaries with stage 3 CKD.[25]

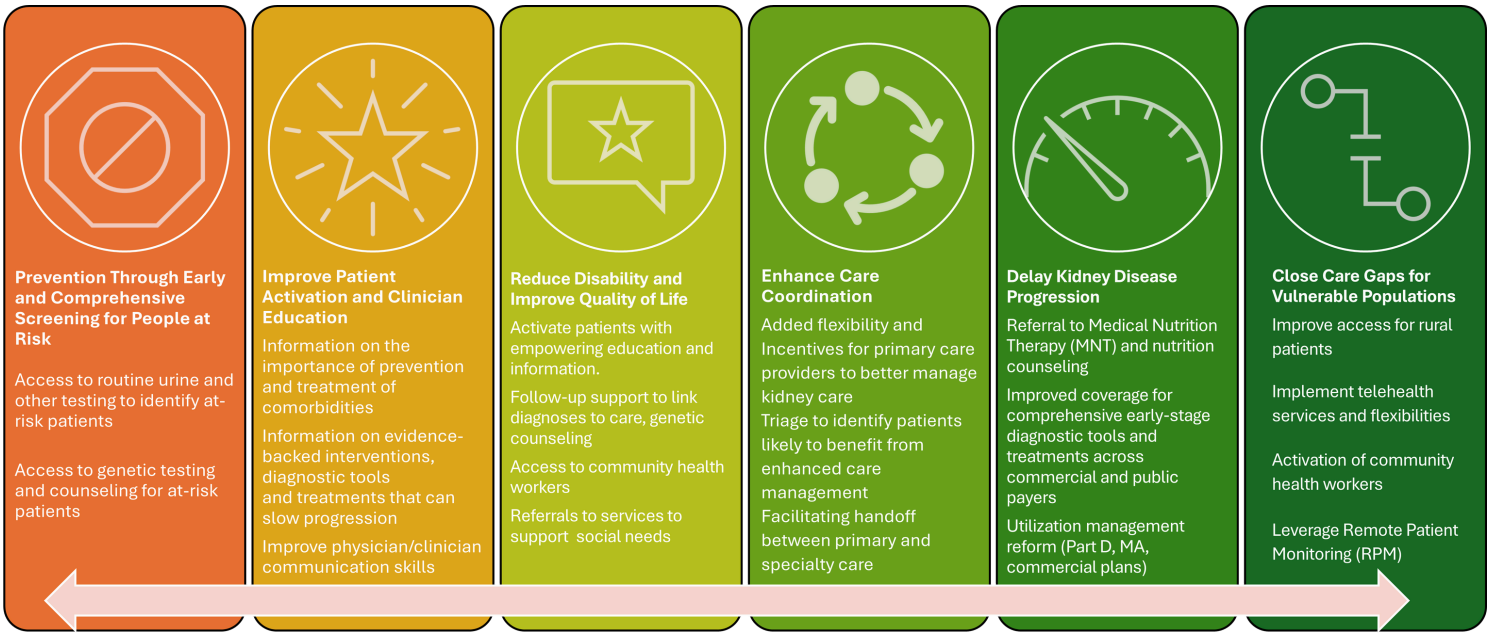
Albuminuria (i.e., the level of the protein albumin in the urine) is both a biomarker of the progression of CKD and a biomarker for the risk of cardiovascular disease. The level of albuminuria is associated with increased risk of CAD, stroke, HF, and microvascular disease, but testing remains low in all populations, including among traditional Medicare and MA beneficiaries.[26] Recommendations throughout this white paper emphasize the need to use the Center's tools to improve urine testing to guide care delivery interventions that triage patients to settings where they can receive high-value care focused on slowing CKD progression and managing comorbid conditions. Notably, recently released clinical practice guidelines from the American College of Cardiology (ACC) and the American Heart Association (AHA) recommend that urinalysis and urine albumin-to-creatinine ratio be performed in adults who are diagnosed with hypertension to optimize management.[27]

Policy Recommendations

The recommendations that follow in the sections below address key goals in improving the patient journey with kidney disease, focused on prevention, improving patient activation and clinician education, improving

coordination between primary and specialty care, providing tailored disease management support, delaying CKD progression, and closing gaps in care for those most vulnerable. These policy goals are outlined in Figure 3.

Figure 3. **Early Chronic Kidney Disease Policy Goals**



Benefit Enhancements (BEs), Beneficiary Engagement Incentives (BEIs), and Other Model Waivers

Section 1115A of the Social Security Act grants the Innovation Center a range of authorities and flexibilities that can be incorporated in the design of models for testing. Broadly, we recommend using these authorities and flexibilities to build on learnings from CMMI's existing kidney models to focus on earlier stages of CKD across the existing model portfolio, including in existing kidney models, and in new models.

Kidney Disease Education Benefit Enhancement

Use the Center's waiver authority to expand access to the Kidney Disease Education (KDE) benefit. Learnings from the ESRD Treatment Choices and Kidney Care Choices (KCC) Model KDE waiver can be applied to other Medicare model frameworks, for example, in ACO REACH and ACO PC Flex, to improve access to empowering kidney disease education across CMMI models **Improve Patient Activation/Delay Kidney Disease Progression/Close Care Gaps**

Medical Nutrition Therapy Benefit Enhancement

Use the Center's waiver authority to waive the eligibility for Medical Nutrition Therapy (MNT) based on the presence of chronic renal insufficiency defined at CFR § 410.130 as the stage of renal disease associated with a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate [GFR] 15-59 ml/min/1.73m^2). Static GFR delineations around eligibility limit access to this proven, guideline-recommended intervention to reduce kidney disease progression, for individuals with CKD and at risk for CKD. CMMI should waive the definition of chronic renal insufficiency across the Center's Medicare model portfolio, for example in ACO REACH, ACO PC Flex, and Kidney Care Choices, thereby allowing access to MNT for any patient with a diagnosis of CKD referred for MNT by a physician.

Delay Kidney Disease Progression

Include Kidney Profile in the Annual Wellness Visit

Use the Center's authority to increase access to kidney disease screening and care plan development as part of the Annual Wellness Visit (AWV) across the Center's Medicare model portfolio, for example by requiring participants in ACO REACH, ACO PC Flex, and other models as appropriate, to offer annual wellness visits consistent with personalized prevention plan services that include the Kidney Profile, defined as an annual eGFR and uACR, among "other routine measurements as deemed appropriate, based on the beneficiary's medical and family history" as codified at § 410.15.

Prevention/Improve Patient Activation/Close Care Gaps

Community Health Worker Benefit Enhancement

Use the Center's waiver authority to expand access to Community Health Workers (CHWs) by increasing flexibility for CHWs and care navigators to bill Medicare for services furnished under the general supervision of a billing practitioners, thereby providing empowering, wraparound support for individuals with CKD, improving care coordination, connecting patients with disease management support, better integrating the handoff from primary to specialty care, and improving health system capacity.

Improve Patient Activation/Reduce Disability and Improve Quality of Life /Delay Kidney Disease Progression/Close Care Gaps

Additional Benefit Enhancements to Enhance Care Connections

Deploy additional Benefit Enhancements (BEs) across the portfolio to improve patient engagement and empowerment through extended coverage for telehealth, home visits, and remote patient monitoring (RPM) to enhance connections between kidney patients and their care.

Reduce Disability and Improve Quality of Life/Close Care Gaps

Multipayer Alignment

Aligning incentives for health plans to invest in the payment policy frameworks and quality programs designed and implemented in the traditional Medicare program is an important element of encouraging providers to invest in their own care delivery reform, as their patient panels generally include patients attributed to multiple different

programs across payers. This alignment is particularly critical in kidney disease, given that kidney patients can move back and forth between commercial payers and Medicare (i.e., kidney patients can qualify for Medicare when they develop ESRD, and then lose Medicare eligibility three years after they obtain a transplant). However, today there is wide variation in health plan commitments to CKD, potentially driven by the historical lack of treatment options for patients with earlier stages of the disease. Given the new tools available to delay and prevent ESRD, now is the time to align incentives across payors—including commercial plans, Medicare Advantage, and Medicaid—to leverage these tools to reduce Medicare costs and improve care quality.

Convene Payers Early in Model Design

Leverage the Learning and Action Network (LAN) to convene payers early in the Center's development of a multi-payer strategy to discuss approaches to aligning with the kidney model portfolio, future iterations of the portfolio, and what incentives the Innovation Center can adopt to invest in and scale kidney disease initiatives, paying particular attention to aligning policy roll-out with plan year and giving plans enough time to consider participation and applying.

Improve Patient Activation/Reduce Disability and Improve Quality of Life /Delay Kidney Disease Progression /Close Care Gaps

Proactive Engagement with Plans

Engage with health plans proactively to create alignment in incentives from the first iteration of a model concept, for example, ensuring new kidney models in the fee-for-service population include a pathway to implement a concomitant incentive to drive aligned behaviors to encourage optimal management of early CKD in the MA and commercial populations, for example, if CMMI advanced a performance-based payment tied to a kidney disease quality measures in the fee-for-service population, work to advance that measure concept with NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) measure set, so that, if the model test is successful, there is a streamlined pathway to implementing performance-based policy in MA and among commercial payers.

Prevention/Improve Patient Activation/Reduce Disability and Improve Quality of Life / Delay Kidney Disease Progression /Close Care Gaps

Medicare Advantage Plan Flexibilities

Leverage the Center's waiver authority to consider a value-based insurance design (VBID)-like approach to give MA plans more flexibility to test approaches to optimal management of CKD, for example reducing cost-sharing and utilization management guardrails for proven therapies and diagnostic tools, and align with the Center's historical focus on advancing kidney-focused value-based care through fee-for-service Medicare.

Prevention/Improve Patient Activation/Reduce Disability and Improve Quality of Life / Delay Kidney Disease Progression /Close Care Gaps

Create Incentives for Plan Intervention to Delay CKD

Use the Center's MA and Medicaid Managed Care Organization (MCO) authorities to develop a reward structure in which health plans are incentivized to deploy guideline-concordant screening, CKD management, and tools guideline-concordant CKD management and diagnostic tools that help delay the progression of CKD.

Prevention/Improve Patient Activation/Reduce Disability and Improve Quality of Life / Delay Kidney Disease Progression /Close Care Gaps

Performance-Based Payment

Innovation Center Models are designed under the expectation that reimbursement should be tied to markers of value, whether certain metrics of utilization, clinical quality measures, or patient-reported outcomes. Performance-based policies are a powerful mechanism to increase clinician and system focus on facilitating routine, guideline-concordant screening and optimal care management with an emphasis on delayed CKD progression.

A recent whitepaper by NCQA, *Advancing Care for Chronic Kidney Disease,* noted the need for developing and adopting quality measures related to CKD prevention, screening and treatment, specifically measures in the domains of best practices for use of medications, management of cardiovascular risk factors, patient education, and patient-centered care planning.[28]

Notably, the Center's MAHA strategy emphasizes deploying tools, programs, and models built on evidence-based prevention. Clinical quality measures are evidence-based tools as clinical practice guidelines (CPGs) are frequently the basis and justification for clinical quality measures. Patient-reported quality measures, which align healthcare system performance with outcomes that are important to people impacted by a disease or condition, are an important approach to achieving the second pillar of the MAHA strategy, empowering people to make decisions about their care in conjunction with their care teams.

Broaden Adoption of Core Screening Measures

The Kidney Health Evaluation for Adults with Diabetes (KED) measure is a core screening measure for kidney disease. KED is an electronic clinical quality measure (eCQM) measuring performance of the kidney health evaluation, including tests for glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (uACR), in adults with diabetes. KED is being used in the Merit-Based Incentive System (MIPS). The health plan version of the measure, developed in partnership with NCQA, is used in the Healthcare Effectiveness Data and Information Set (HEDIS) and in the MA Star Ratings. Adopt the KED measure in quality measure sets focused on advanced primary care management in ACO REACH and ACO PC Flex.

Prevention/Improve Patient Activation/Reduce Disability and Improve Quality of Life / Delay Kidney Disease Progression /Close Care Gaps

Expand Kidney Care Choices

Accountability for participants in the KCC Model begins with beneficiaries with CKD stage 4. Iterate on the KCC framework to increase multiple types of specialist engagement (nephrology, cardiology, obesity medicine etc.) in delaying kidney disease progression. Include incentives for specialists to coordinate with primary care to focus on prevention and upstream management of kidney disease.

Prevention/Improve Patient Activation/Reduce Disability and Improve Quality of Life / Delay Kidney Disease Progression /Close Care Gaps

Fraud and Abuse Waivers

Implement financial arrangements through the CMS-sponsored model safe harbor and other fraud and abuse flexibilities to support co-management of patients and care coordination across provider types and settings where kidney disease is managed.

Prevention/Delay Kidney Disease Progression/Enhance Care Coordination

Increase Accountability for Patient Activation

The Patient Activation Measure is a validated quality measure based on a survey that assesses an individual's knowledge, skills and confidence integral to managing one's own health. PAM is a concrete mechanism through which to emphasize the importance of patient activation to improving adherence and clinical outcomes in individuals with kidney disease.

Prevention/Improve Patient Activation/Close Care Gaps

Facilitating Patient Activation and Clinician Education

The Innovation Center's Learning and Diffusion Group operates the HCPLAN which is responsible for thought leadership, strategic direction, and ongoing support to accelerate the adoption of accountable care and model learning systems, that support and disseminate learning under a specific model's framework. LDG can facilitate a range of activities to support patient activation and clinician education in the service the early kidney disease policy goals and the MAHA strategy to emphasize prevention and early intervention.

Leverage Data and Technology to Enable Real-Time Insights

Advance opportunities to succeed in kidney-focused care and catalyze the free flow of data by leveraging model requirements to drive interoperability, data standards, and data accessibility and transformation forward enable model participants to gain real-time insights into utilization and spending data, facilitate alignment across payers by advancing the sophistication of model participants in interacting with payer and provider APIs and facilitate data exchange between CMMI, patients, and model participants.

Prevention/Improve Patient Activation/Enhance Care Coordination

Create Digital Tools to Drive Patient Activation

Use CMMI resources to generate patient-facing digital tools to improve activation, and additional artificial intelligence (AI) and other advanced analytic capabilities, for example, building on the Artificial Intelligence (AI) Health Outcomes Challenge, to identify early-stage kidney disease patients at the greatest risk of disease progression and streamline co-management of kidney disease between primary and specialty care. In the case of patient-facing digital tools, deploy them in the context of a model where a model evaluation can inform learnings about how to engage patients of varying health literacy and digital fluency in health technologies

Improve Patient Activation/Enhance Care Coordination

Support Diffusion of the Kidney Failure Risk Equation

The Kidney Failure Risk Equation (KFRE) is a math equation that can predict a patient's risk for reaching kidney failure within 2 or 5 years. Similar tools to support risk identification and patient triage are advancing. The Innovation Center should support dissemination of tools like KFRE through model learning systems and the HCPLAN.

Prevention/Delay Kidney Disease Progression/Enhance Care Coordination

Beneficiary Journey Mapping

Patient journey mapping is a tool that represents a patient's journey through the treatment process to identify pain points in a patient's experience. The Learning and Diffusion Group (LDG) should convene patient groups and other interested parties to develop a beneficiary journey map that can be used to identify and act on opportunities to elevate kidney disease across the center. A beneficiary journey map is particularly important in kidney disease care delivery innovation because of the heterogeneity in patient experience depending on the type of kidney disease and the setting in which it is identified and treated

Prevention/Improve Patient Activation/Reduce Disability and Improve Quality of Life / Delay Kidney Disease Progression /Close Care Gaps

Population Health Models

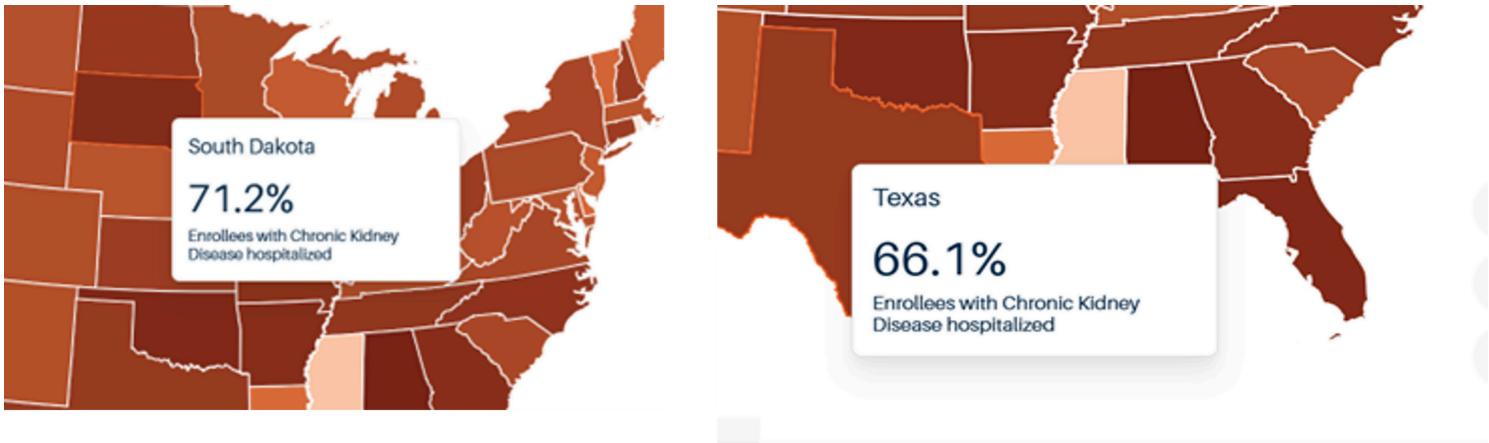
Population health interventions work to achieve better health outcomes for whole population rather than for individual patients. Addressing CKD through population health models is an evidence-backed approach to transforming care delivery with the goal of transforming upstream care delivery for CKD. Several notable examples include:

- A population health approach to diabetes care implemented through the Indian Health Service that resulted in a 54% decrease in the incidence of ESRD based simply on closing gaps in blood glucose and blood pressure control and use of guideline-directed therapy in the primary care setting.[28]
- A CKD intervention embedded into a primary care patient-centered medical home model, developed and tested by The National Kidney Foundation (NKF) and CareFirst, resulted in reductions in hospital admissions, remissions, and generated net savings.[29]
- An electronic health record (EHR)-based population health intervention based at the University of Pittsburgh Medical Center (UPMC) that improved exposure to guideline-directed medical therapy over a median follow-up of 17 months.[30]

- The National Kidney Foundation's CKDIntercept initiative, which aims to improve chronic kidney disease (CKD) testing, recognition, and management in primary care. A collaboration with Sanford Health, the largest rural health system in the country, resulted in the percentage of patients with diabetes receiving an eGFR and uACR test rose from 38 to 70 percent, diagnosis of CKD in patients with laboratory evidence increased from 20 to 73 percent and use of medications that are proven to slow CKD progression rose from under 2 percent to 9.6 percent.[31]

The Center's state and community-based model portfolio should be leveraged to scale the impact of population health approaches to CKD detection and management across both primary and specialty care. The CKDSpotlight tool, developed by the National Kidney Foundation in partnership with the Health Care Cost Institute, can be used to target model concepts to states with especially high burdens of CKD associated utilization (Figure 5).

Figure 5. **Rates of Hospitalization Among Medicaid Beneficiaries with CKD in Texas and South Dakota, 2022**



State-Based Models

States carry much of the burden of CKD. Medicaid beneficiaries with multiple chronic conditions are disproportionally responsible for program utilization and spending.[32] Chronic diseases like kidney disease have a dramatic impact on a state's workforce through lost productivity and increasing costs of coverage through employer Group Health Plans. The Innovation Center could provide state Medicaid agencies with technical support and funding to adopt and scale population health approaches to CKD. Notably, this model concept could build on foundational work in select states where a collective impact (CI) model rooted in a data strategy, stakeholder and relationship mapping, learning in action workgroups and leadership summits are being advanced to address the public health burden of CKD in a state-specific manner, for example, Show Me CKDintercept in Missouri.[33]

Prevention/Improve Patient Activation/Reduce Disability and Improve Quality of Life /Delay Kidney Disease Progression/Close Care Gaps

Medicaid Models

Execute cooperative agreements with state Medicaid agencies to use a data strategy to reveal CKD burden and subsequently improve quality and reduce costs associated with CKD care, expand service-delivery capacity aligned with the needs specific to states, and create payment strategies that support care coordination.

Prevention/Improve Patient Activation/Reduce Disability and Improve Quality of Life/ Delay Kidney Disease Progression/Close Care Gaps

State-Based Models Focused on Dual Eligibles

Enter into Memorandum of Understandings (MOUs) with states to support care coordination activities specifically focused on detection of CKD and subsequent coordination of care between primary care and specialty care providers. The Center could consider capitated or managed fee-for-service models, following the framework of the Financial Alignment Initiative for Medicare-Medicaid Enrollees.[34]

Prevention/Improve Patient Activation/Reduce Disability and Improve Quality of Life / Delay Kidney Disease Progression /Close Care Gaps

Conclusion

The moment is right for CMS to prioritize prevention and early intervention in kidney disease, one of America's leading causes of death and disability. The White House is charting a bold course to Make America Healthy Again. The CMS Innovation Center has an essential role in achieving the President and Secretary's goals by leveraging its authorities to pivot the focus of the Center to prevention and treatment of CKD. Incorporating policies focused on early intervention of CKD across the model portfolio would make a material difference to the health of the country. The Coalition for Kidney Health encourages the Center to consider the recommendations herein and work with the Coalition membership to test tactical approaches to Making America Healthy Again.

Appendix

The Innovation Center’s Commitment to Kidney Disease

The Innovation Center is committed to transforming care for Medicare beneficiaries with kidney disease. The ESRD Treatment Choices (ETC) and Kidney Care Choices (KCC) models were pillars of President Trump’s 2019 Executive Order on Advancing American Kidney Health.

As the Innovation Center’s kidney portfolio has evolved, it has evolved towards higher value treatment of the consequences of undiagnosed and unmanaged CKD rather than towards detecting and treating kidney disease at the earliest timepoint possible.

The ETC and KCC Models have shown promising effects on quality. Beneficiary access to the dialysis modality of their choice is expanding.

The first evaluation of the KCC Model found increases in home dialysis training, use of home dialysis modalities, optimal end-stage renal disease (ESRD) starts, and in the proportion of aligned beneficiaries with an active status on the kidney transplant waitlist. The Innovation Center recently finalized the Increasing Organ Transplant Access (IOTA) Model, further demonstrating the center’s commitment to leveraging accountable care frameworks to secure optimal outcomes for beneficiaries with kidney disease.

Glossary

Benefit Enhancement is defined as conditional waivers of certain Medicare payment rules. CMS uses the authority under Section 1115A of the Social Security Act to waive certain Medicare payment requirements to emphasize high-value care, support care coordination, and provide greater flexibility to participants to achieve model goals.

Beneficiary Engagement Incentive is defined as remuneration that is furnished to a patient under the terms of a CMS-sponsored model consistent with the anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives described at 42 CFR 1001.952(ii)(2).

Kidney Profile is defined as the combination of two tests, estimated glomerular filtration rate (eGFR) and urine albumin-creatinine ratio (uACR), which taken together support early detection of chronic kidney disease.

Patient Activation is defined as having the knowledge, skill, and confidence to manage one's health and healthcare.

References

1. https://www.ncqa.org/white-papers/advancing-care-for-chronic-kidney-disease-using-care-gaps-to-inform-a-quality-framework/
2. https://www.whitehouse.gov/maha/
3. https://www.cdc.gov/kidney-disease/php/data-research/index.html
4. https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf
5. Hoerger TJ, Wittenborn JS, Segel JE, et al; Centers for Disease Control and Prevention CKD Initiative. A health policy model of CKD: 2. the cost-effectiveness of microalbuminuria screening. Am J Kidney Dis. 2010;55(3):463-473. doi: 10.1053/j.ajkd.2009.11.017.
6. https://www.ajmc.com/view/ckd-quality-improvement-intervention-with-pcmh-integration-health-plan-results
7. https://www.ajmc.com/view/ckd-quality-improvement-intervention-with-pcmh-integration-health-plan-results
8. https://www.kidney.org/professionals/ckdintercept
9. https://www.cdc.gov/kidney-disease/php/data-research/index.html
10. *Ibid*.
11. https://www.freseniuskidneycare.com/kidney-disease/ckd/causes
12. https://www.ncbi.nlm.nih.gov/books/NBK560644/
13. https://usrds-adr.niddk.nih.gov/2023/chronic-kidney-disease/3-morbidity-and-mortality-in-patients-with-ckd
14. https://usrds-adr.niddk.nih.gov/2023/chronic-kidney-disease/6-healthcare-expenditures-for-persons-with-ckd
15. https://usrds-adr.niddk.nih.gov/2023/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd
16. Ibid.
17. Kidney disease in the elderly a case-based guide. (2024). SPRINGER INTERNATIONAL PU.
18. https://journals.lww.com/cjasn/fulltext/2023/11000/a_policy_call_to_address_rare_kidney_disease_in.22.aspx
19. Seshan SV, Salvatore SP. Recurrent Glomerular Diseases in Renal Transplantation with Focus on Role of Electron Microscopy. Glomerular Dis. 2021 Jul 20;1(4):205-236. doi: 10.1159/000517259. PMID: 36751386; PMCID: PMC9677743.
20. Ndumele CE, Rangaswami J, Chow SL, et al. Cardiovascular-Kidney-Metabolic Health: A Presidential Advisory From the American Heart Association. Circulation. 2023;148(20):1606-1635. doi:10.1161/CIR.0000000000001184
21. Jankowski J, Floege J, Fliser D, Böhm M, Marx N. Cardiovascular Disease in Chronic Kidney Disease: Pathophysiological Insights and Therapeutic Options. Circulation. 2021;143(11):1157-1172. doi:10.1161/CIRCULATIONAHA.120.050686
22. https://www.heart.org/en/professional/cardiovascular-kidney-metabolic-health
23. Ibid.
24. https://usrds-adr.niddk.nih.gov/2024/chronic-kidney-disease/6-healthcare-expenditures-for-persons-with-ckd
25. https://usrds-adr.niddk.nih.gov/2024/chronic-kidney-disease/3-morbidity-and-mortality-in-patients-with-ckd
26. https://www.ahajournals.org/doi/10.1161/JAHA.123.030131
27. https://www.jacc.org/doi/10.1016/j.jacc.2025.05.007
28. Narva A. Population Health for CKD and Diabetes: Lessons From the Indian Health Service. Am J Kidney Dis. 2018 Mar;71(3):407-411. doi: 10.1053/j.ajkd.2017.09.017. Epub 2017 Dec 6. PMID: 29221625; PMCID: PMC5828878.
29. https://www.ajmc.com/view/ckd-quality-improvement-intervention-with-pcmh-integration-health-plan-results
30. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2817606
31. https://www.kidney.org/press-room/nkf-sanford-health-earn-univants-healthcare-excellence-award-transforming-ckd-care
32. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-coverage-for-adults-with-chronic-conditions/
33. https://pmc.ncbi.nlm.nih.gov/articles/PMC10821387/
34. https://www.cms.gov/priorities/innovation/innovation-models/financial-alignment