Fact sheet

Kidney Care Choices (KCC) Model

This is an updated version of the fact sheet originally posted on December 4, 2019.

Overview

The Kidney Care Choices (KCC) Model builds upon the Comprehensive End Stage Renal Disease (ESRD) Care (CEC) Model structure – in which dialysis facilities, nephrologists, and other health care providers form ESRD-focused accountable care organizations – by adding strong financial incentives for health care providers to manage the care for Medicare beneficiaries with chronic kidney disease (CKD) stages 4 and 5 and ESRD. The model's goals include improved care, delay in the onset of dialysis, and increased rates of kidney transplantation. The Model includes four options: the CMS Kidney Care First (KCF) Option, the Comprehensive Kidney Care Contracting (CKCC) Graduated Option, the CKCC Professional Option, and the CKCC Global Option. The KCF Option ended December 31, 2025.

Is participation in the KCC Model required for health care providers?
Participation is voluntary for health care providers.

Who is participating in the Model?
The participants continuing the model for PY 2026 are 74 KCEs, which includes participants who joined the model in PY 2022 (starting January 1, 2022) and PY 2023
(starting January 1, 2023). The KCEs will serve Medicare fee for service beneficiaries in 40 states as well as in the District of Columbia. In PY 2026, 35 KCEs will participate in the CKCC Global Option and 39 will participate in the CKCC Professional Option**.**

What are the Model's goals, and how will the Model achieve these goals?
The Model is designed to incentivize better management of kidney disease. A group of health care providers form a Kidney Contracting Entity (KCE) and is responsible for aligned beneficiaries' kidney care from the late stages of CKD or ESRD through dialysis, kidney transplantation, and post-transplant care. The Model includes financial incentives to encourage KCEs to furnish care that meets beneficiaries' health needs by encouraging them to best guide their aligned beneficiaries through the course of their CKD stage 4 or 5 or ESRD. In particular, KCEs focus on delaying the progression of CKD to ESRD, managing the transition onto dialysis, supporting beneficiaries through the transplant process, and keeping beneficiaries healthy post-transplant.

The patient is a key component of the Model's design. The tendency now is for patients with kidney disease to follow the most expensive treatment path, with little prevention of disease progression and an unplanned start to in-center hemodialysis treatment. By increasing education and understanding of the kidney disease process, aligned beneficiaries may be better prepared to actively participate in shared decision making for their care.

The Model avoids the potential for care stinting through risk adjustment and application of quality measures, as well as monitoring activities that will ensure beneficiaries receive needed services, while retaining freedom of choice of providers.

How does the Model build upon the CEC Model?
This Model builds on key lessons and areas for improvement recognized from the CEC Model by:

- Including Medicare beneficiaries with CKD stage 4 and 5 before they progress to ESRD, to promote later and better starts on dialysis, or to avoid dialysis entirely.
- Including beneficiaries after they receive a transplant and incorporating financial incentives to promote greater utilization of transplants.
- Empowering nephrologists to take the lead in coordinating care for beneficiaries across the care spectrum.
- Incorporating Medicare Benefit Enhancements to support improved utilization of skilled nursing facilities (SNFs), increase telehealth utilization, and increased utilization of the kidney disease education (KDE) benefit.
- Altering nephrologist payment policy in order to reduce burden and better align payments with care.

What is the timeline for implementation of the KCC Model?

The KCC Model Performance Period began on January 1, 2022, and will continue through December 31, 2027. CMS solicited applications for the first cohort of KCC Model participants in October 2019. Healthcare providers interested in participating applied by January 22, 2020. Applicants selected for participation in the first cohort began an Implementation Period in late 2020, to focus on building necessary care relationships and infrastructure. The Implementation Period extended through 2021 to enable model participants to prepare to take on financial and population health accountability starting in January 2022. The first cohort of KCC Model participants began their participation in the Model performance period on January 1, 2022.

CMS then solicited applications for the second cohort of the KCC Model participants in January 2022 with a deadline of March 25, 2022. Applicants selected for participation began their participation in the Model performance period beginning on January 1, 2023.

CMS does not plan to conduct any further solicitations for KCC Model participants.

Who is eligible to participate in the Model?

KCEs participating in one of the Comprehensive Kidney Care Contracting Options are required to include at least one Nephrologist and at least one transplant provider, while dialysis facilities and other providers and suppliers are optional participants in KCEs.

How will beneficiaries be aligned to the Model?

Alignment is based on beneficiary claims. To be eligible to be aligned or remain aligned to a KCE, a beneficiary must meet one of the following conditions (as well as satisfy other relevant eligibility criteria):

- Medicare beneficiaries with CKD stages 4 and 5.
- Medicare beneficiaries with ESRD receiving maintenance dialysis.
- Medicare beneficiaries who were aligned to a KCE by virtue of having CKD stage 4 or 5 or ESRD and receiving dialysis that then receive a kidney transplant.

Alignment is based on where a beneficiary receives the majority of their kidney care. When an aligned beneficiary receives a kidney transplant, they will typically remain aligned to the model participant for three years following a successful kidney transplant or until the time a kidney transplant fails, at which point the beneficiary could be re-aligned if they meet the requirements for alignment by virtue of their ESRD.

What is the payment methodology for the Comprehensive Kidney Care Contracting Options?
KCEs receive adjusted payments for managing beneficiaries with CKD Stages 4 and 5 and ESRD.

The CKCC Options have three distinct accountability frameworks:

- CKCC Graduated Option: Allows certain participants to begin under a lower-reward one-sided model and incrementally phase into greater risk and greater potential reward.
- CKCC Professional Option: Provides an opportunity to earn 50% of shared savings or be liable for 50% of shared losses based on the total cost of care for Part A and B services.
- CKCC Global Option: Holds entities accountable with risk for 100% of the total cost of care for all Parts A and B services for aligned beneficiaries.

  The KCC Model aims to attract diverse types of health care providers operating under a common governance structure, with attention given to improved care for the affected population to reduce expenditures. CMS has established requirements for a KCE's governance structure and beneficiary alignment, in addition to the payment, financial accountability, risk adjustment, and overlap rules.

Can KCEs qualify as Alternative Payment Model (APM) Entities?
KCEs in the CKCC Professional or Global Option qualify as Advanced APM entities beginning with 2022, assuming that they meet the payment or patient thresholds required under the Quality Payment Program. The CKCC Graduated Level 1 Risk Option does not qualify as an Advanced APM, however, the CKCC Graduated Level 2 Risk Option is considered an Advanced APM.

Are there any Medicare benefit enhancements under the Model?
These Medicare benefit enhancements (BEs) are available for participants of the KCC Model:

- Kidney Disease Education – Medicare currently covers up to six 1-hour sessions for beneficiaries with stage 4 CKD. The BE allows practitioners other than currently permitted clinicians to provide this service, and also allows the service to be furnished to beneficiaries with stage 5 CKD and certain beneficiaries with ESRD.
- Telehealth – This Telehealth BE further increases the availability to beneficiaries of otherwise covered telehealth services furnished via interactive telecommunications systems while also providing flexibility for beneficiaries to receive certain tele-dermatology and teleophthalmology services furnished using asynchronous store and forward technologies.
- 3-day skilled nursing facility (SNF) rule – CMS waives the requirement in section 1861(i) of the Act for a three-day inpatient hospital stay prior to the provision of otherwise covered Medicare post-hospital extended care services.
- Post-discharge home visit – Increases the availability to beneficiaries of in-home care following discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or SNF by altering the supervision level for "incident to" services to allow personnel under a physician's general supervision (instead of direct supervision) to make home visits under certain conditions.
- Home Health Homebound waiver – CMS waives the requirements of 42 CFR § 409.42(a) that the beneficiary must be confined to the home or in an institution that is not a hospital, SNF, or nursing facility to qualify for Medicare coverage of home health services and also waives the requirements of §1814(a)(2)(C) and §1835(a)(2)(A) that the certification (or recertification) for home health services include a certification (or recertification) that such services are or were required because the individual is or was confined to their home as defined at 42 CFR § 409.42(a).
- Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit: CMS waives the requirement in Section 1812 of the Act (and the implementing regulations at 42 CFR § 418.24(f)(2)) to forgo curative care as a condition of electing the hospice benefit and instead receive care with respect to their terminal illness.

How will the Model be evaluated?

An independent evaluation will be conducted for the Model. Each evaluation will assess the impact of the Model, as well as the effectiveness of implementation. The evaluation strategy reflects the need for rapid-cycle findings that will be available to CMS and model participants throughout the model test. The evaluation will employ a mixed-methods approach using quantitative and qualitative data to measure both the impact of the Model and implementation effectiveness. The impact analysis will examine the effect of the Model on key outcomes, including improved quality of care and quality of life, and decreased Medicare expenditures and utilization. The implementation component will describe and assess how participants implement the model, including barriers to and facilitators of change. Findings from both the impact analysis and the implementation assessment will be synthesized to provide insight into what worked and why, and to inform OACT certification and the HHS Secretary's determinations on model expansion, in accordance with Sec. 1115A(c) [42 U.S.C. 1315a].