

# Cross-Model Office Hours Session

Primary Care First, Direct Contracting, and Kidney Care Choices

December 19, 2019

Center for Medicare and Medicaid Innovation  
Centers for Medicare & Medicaid Services (CMS)



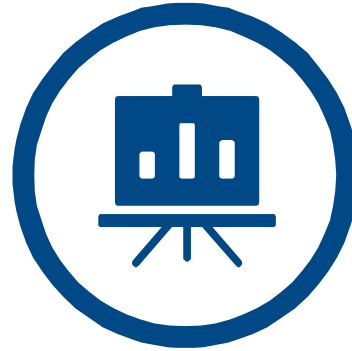
# Presentation Overview

- Overview of Primary Care First Model Options
- Overview of Direct Contracting Model
- Overview of Kidney Care Choices Model
- Comparison of the Three Models
- Q&A

# Today's Presenters

- **Pauline Lapin**, Director, Seamless Care Models Group
- **Gabrielle Schechter**, Primary Care First Lead
- **Emily Johnson**, Primary Care First Seriously Ill Population Lead
- **Nicholas Minter**, Director, Division of Advanced Primary Care
- **Perry Payne, Jr.**, Direct Contracting Model Co-Lead
- **Kate Blackwell**, Kidney Care Models Lead

# Audience Poll



**About which model(s) would you like to receive more information?**

- a) Primary Care First
- b) Direct Contracting
- c) Kidney Care Choices
- d) All three models and their differences
- e) Unsure

# Primary Care First Model Options

# Introduction to Primary Care First (PCF)

## Primary Care First Goals

1

To **reduce Medicare spending** by preventing avoidable inpatient hospital admissions

2

To **improve quality of care and access to care** for all beneficiaries, particularly those with complex chronic conditions and serious illness

## Primary Care First Overview



**5-year** alternative payment model



Offers greater **flexibility**, increased **transparency**, and **performance-based** payments to participants



Payment options for practices that specialize in **patients with complex chronic conditions** and high need, **seriously ill populations**



Fosters **multi-payer alignment** to provide practices with resources and incentives to enhance care for all patients, regardless of insurer

# PCF Payment Model Options

The three Primary Care First payment model options accommodate for a continuum of providers that specialize in care for different patient populations.

## Option 1

### PCF-General Component

Focuses on **advanced primary care practices ready to assume financial risk** in exchange for reduced administrative burden and performance-based payments.

## Option 2

### SIP Component

Promotes care for high-need, **seriously ill population (SIP)** beneficiaries who lack a primary care practitioner and/or effective care coordination.

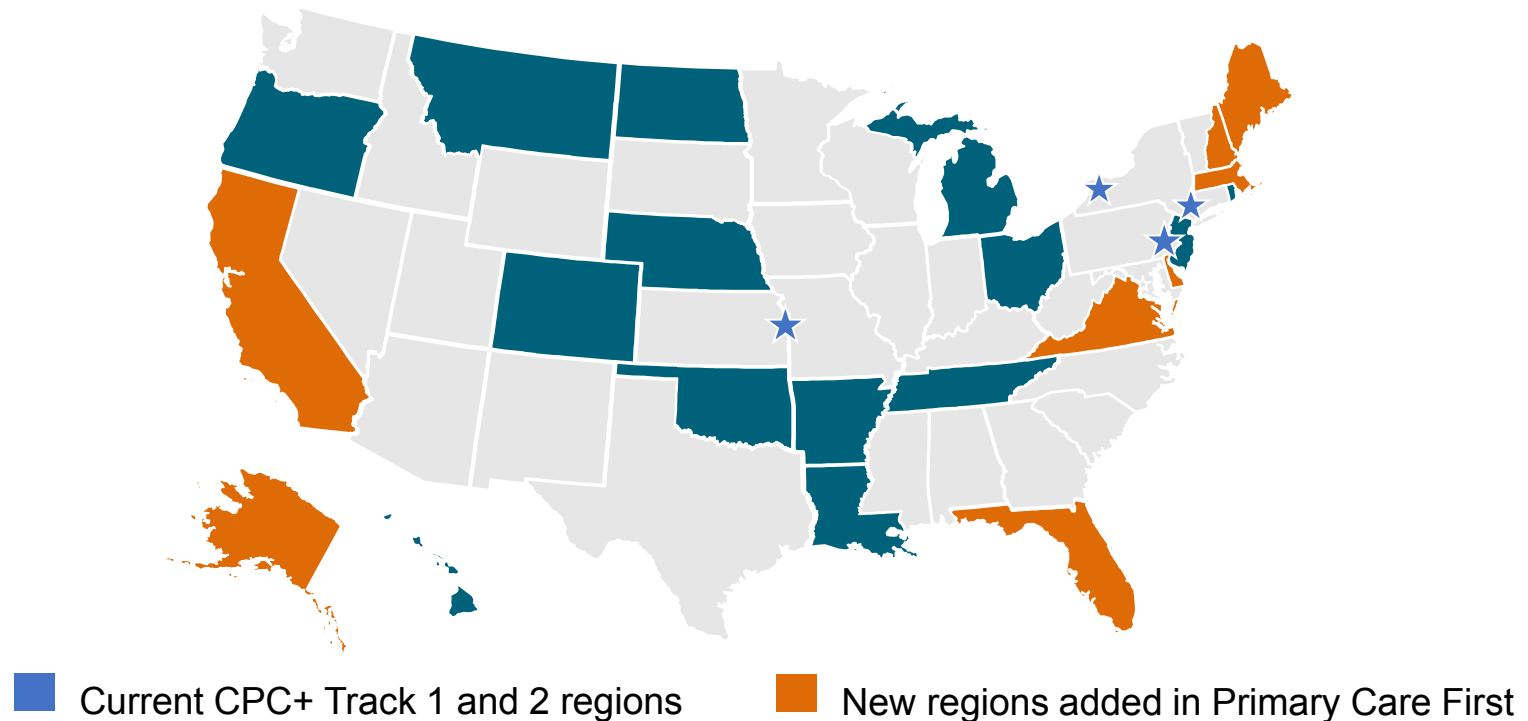
## Option 3

### Both PCF-General and SIP Components

Allows practices to **participate in both** the PCF-General and the SIP components of Primary Care First.

# Where PCF Will Be Offered in 2021

In 2021, Primary Care First will include **26 diverse regions**:



Practices that are **currently not participating in CPC+ but are located in a CPC+ region may be eligible to apply**. Current CPC+ practices may participate in Primary Care First beginning in 2022.



# PCF Payment Model Option Eligibility Criteria

The following criteria apply to practices who seek to participate in the general Primary Care First payment model or in both the general and SIP payment models.



In the application, you will need to attest that you meet the following criteria:

- ✓ Include **primary care practitioners** (MD, DO, CNS, NP, PA) in good standing with CMS
- ✓ Provide health services to a **minimum of 125** attributed Medicare beneficiaries
- ✓ Have primary care services account for at least **70% of the practices' collective billing** based on revenue
- ✓ Demonstrate **experience with value-based payment arrangements**
- ✓ Meet **technology standards** for electronic medical records and data exchange
- ✓ Provide a set of **advanced primary care delivery** capabilities

**Note:** Practices participating in the SIP option will be subject to requirements discussed later in this presentation.



# PCF-General Model Option Payment Structure

The Total Primary Care Payment is a hybrid payment that incentivizes advanced primary care while **compensating practices that care for higher-risk patients** for the increased level of care these patients typically need.

## Population-Based Payment

Payment for service in or outside the office, adjusted for practices caring for higher risk populations. This base rate is the same for all patients within a practice.



## Flat Primary Care Visit Fee

Payment for in-person treatment that reduces billing and revenue cycle burden.

**\$40.82**

**per face-to-face encounter**

*Payment amount does not include copayment or geographic adjustment*

Practice Risk Group	Payment (per beneficiary per month*)
<b>Group 1:</b> Average Hierarchical Condition Category (HCC) <1.2	\$28
<b>Group 2:</b> Average HCC 1.2-1.5	\$45
<b>Group 3:</b> Average HCC 1.5-2.0	\$100
<b>Group 4:</b> Average HCC >2.0	\$175

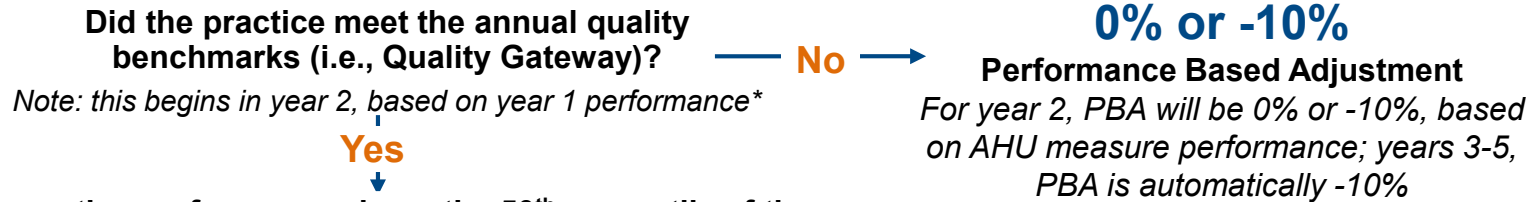
These payments allow practices to:

- ✓ Easily predict payments for face-to-face care
- ✓ Spend less time on billing and coding and more time with patients

Payment will be reduced through calculating a “leakage adjustment” if beneficiaries seek primary care services outside the practice.

\* PBPM = Per Beneficiary Per Month

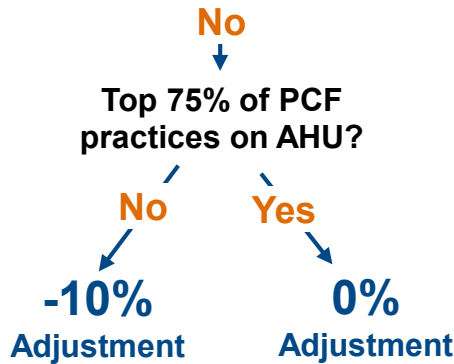
# Performance-Based Payment Adjustments



Is practice performance above the 50<sup>th</sup> percentile of the national Acute Hospital Utilization (AHU) benchmark? — **Yes** →

**1**

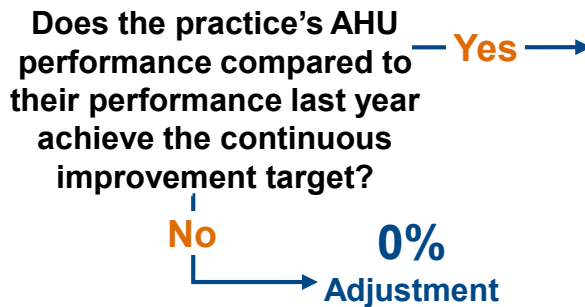
**Regional Adjustment**



AHU Measure Performance	TPCP Adjustment
Top 10% of regional practices	34%
11-20% of regional practices	27%
21-30% of regional practices	20%
31-40% of regional practices	13%
41-50% of regional practices	6.5%
51-75% of regional practices	0%
Bottom 25% of regional practices	-10%

**2**

**Continuous Improvement Adjustment**



AHU Measure Performance	TPCP Adjustment
Top 10% of regional practices	16%
11-20% of regional practices	13%
21-30% of regional practices	10%
31-40% of regional practices	7%
41-50% of regional practices	3.5%
51-75% of regional practices	3.5%
Bottom 25% of regional practices	3.5%

\* Performance-based adjustments in year 1 are based on performance on the AHU measure only and does not follow the above process.

# The SIP Model Option Aims to Transform Care for High-Need Patients

## Goals of SIP Model Option



**Offer a transitional high touch, intensive intervention** to help stabilize SIP patients, promote relief from symptoms, pain, and stress, develop a care plan, and transition them to a provider who can take responsibility for their longer-term care needs



**Provide participating practices with additional financial resources** to proactively engage SIP patients, address their intensive care needs, and help them achieve clinical stabilization and transition



**Transform high-need patient care into a replicable population-health initiative** that is patient-centered and supports long-term chronic care management



# Overview of the SIP Practice Journey



**CMS Identifies SIP Patients:** CMS uses claims data to identify beneficiaries in designated service areas. Practice seeks to make contact as soon as possible with interested SIP patients.



**Practice Engages New SIP Patients:** Practice administers a face to face visit with patient within 60 days of identification.

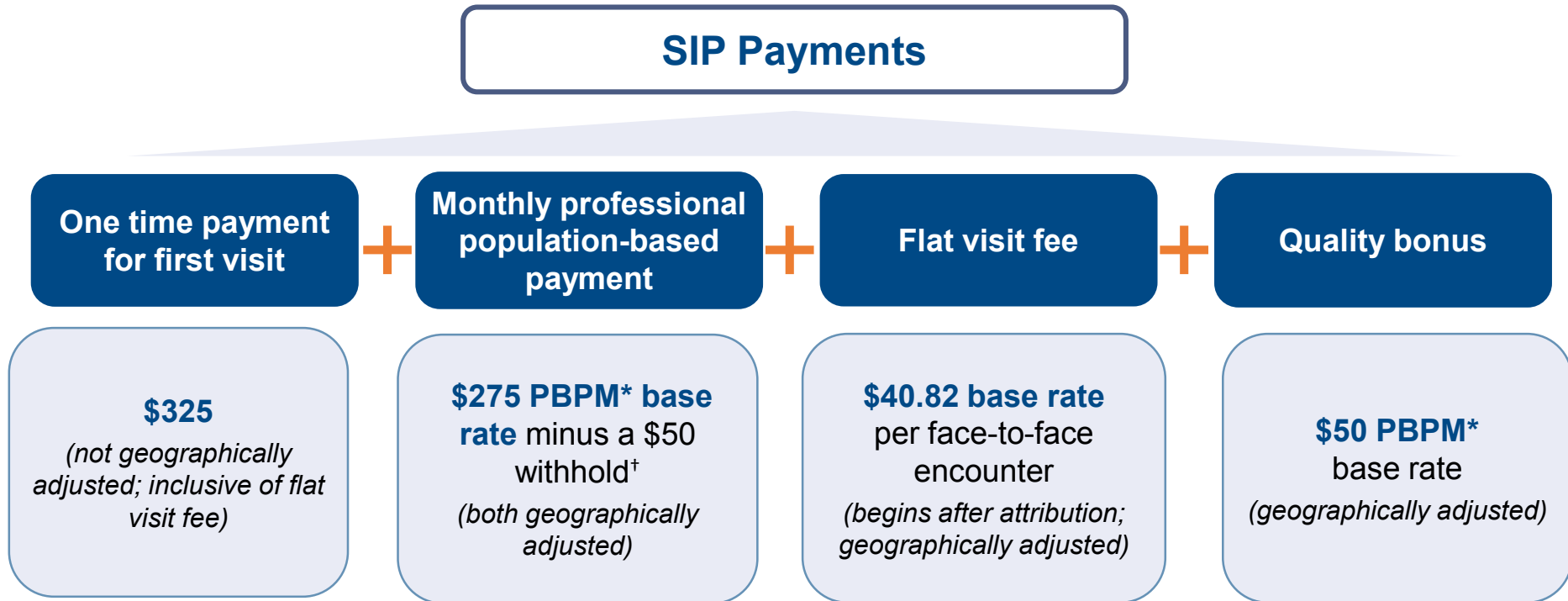


**Practice Administers Care:** Practice provides treatment and care coordination for attributed SIP patients. Practice receives payment adjustments based on quality of care.



**Patient Transitioned Out of SIP Payment Model Option:** Practice transitions patient to long-term care setting or other eligible provider. Practice no longer receives SIP payment for transitioned patients.

# SIP Model Option Payment Structure



***By default, SIP practices will receive up to 12 months<sup>‡</sup> of SIP payments per SIP patient, unless the beneficiary is transitioned or de-attributed sooner. Additional payments beyond 12 months may be allowed as appropriate on a per patient basis subject to CMS approval and practice eligibility.***

\*PBPM = per beneficiary per month

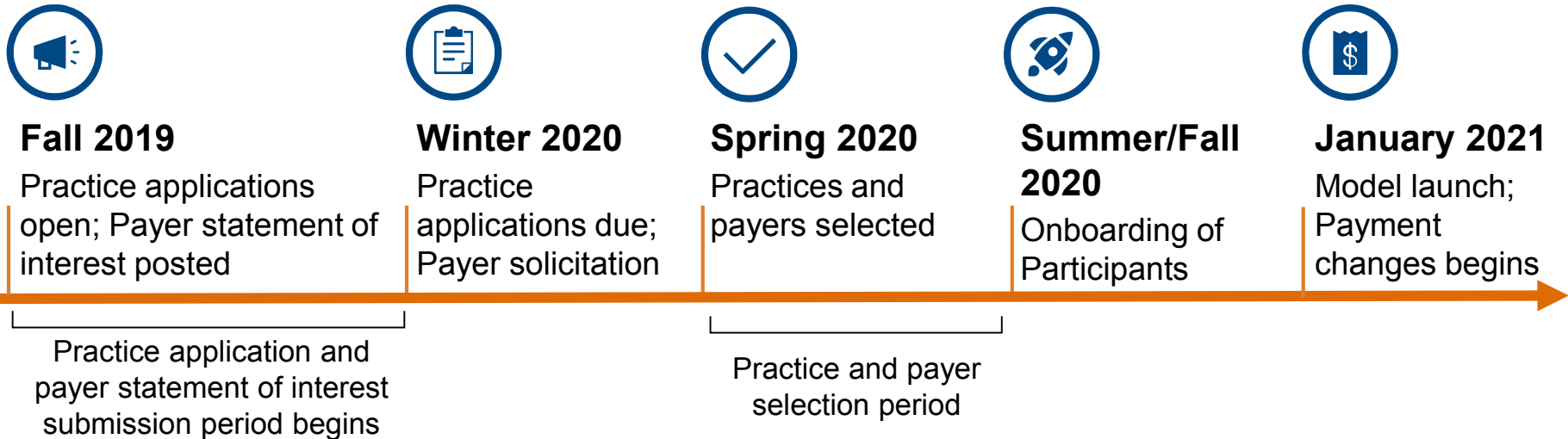
† SIP practices will have the opportunity to earn back the \$50 PBPM base rate withhold from their SIP PBPM payment.

‡ Exceptions may apply. Please see the Request For Applications (RFA) for more details.

# Primary Care First Timeline

**The Primary Care First application portal is now live!**

Please complete your Primary Care First practice application by **January 22, 2020**.



Interested practices should review the [Request for Applications \(RFA\)](#) and can access the [Application Portal](#) to complete an application.

# Direct Contracting Model



# Model Goals and Approach

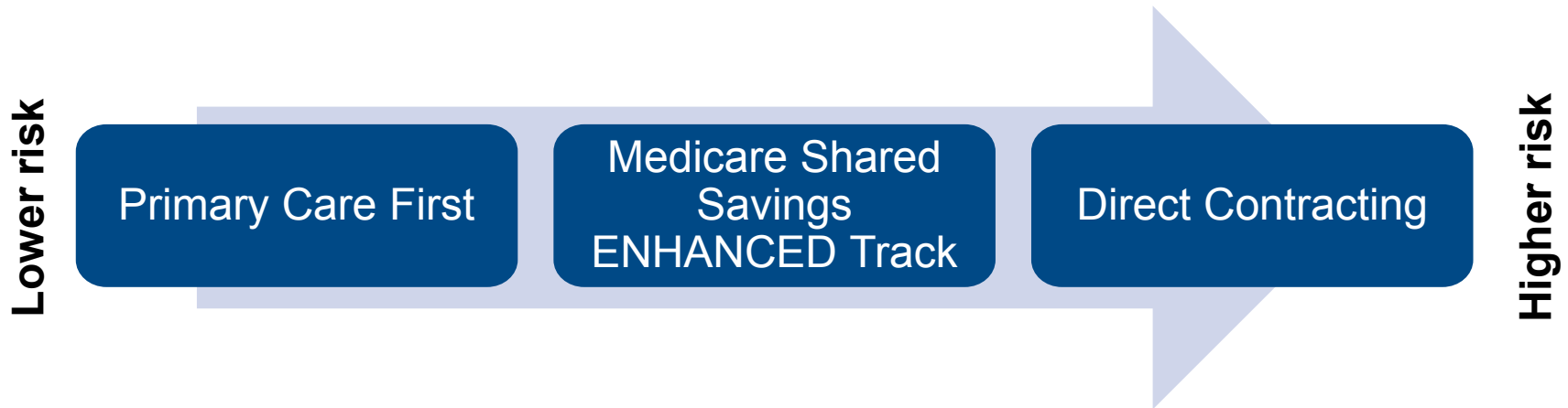
## Goal

## How CMS expects that Direct Contracting will achieve these goals

Transform risk-sharing arrangements	<ul style="list-style-type: none"><li>• Flexible cash flows</li><li>• Predictable, prospective spending targets</li><li>• Payment that recognizes the challenges of caring for complex chronically ill populations</li></ul>
Empower and engage beneficiaries	<ul style="list-style-type: none"><li>• Enhanced voluntary alignment</li><li>• Various benefit enhancements and patient engagement incentives</li></ul>
Reduce provider burden	<ul style="list-style-type: none"><li>• Small set of core quality measures</li><li>• Waivers to facilitate care delivery</li><li>• Opportunities for organizations new to Medicare FFS to participate</li></ul>

# Background of Direct Contracting

- Direct Contracting Model (Direct Contracting), together with the Primary Care First Model and the updated Medicare Shared Savings Program ENHANCED Track, are part of the CMS strategy to use the redesign of primary care to drive broader delivery system reform to improve health and reduce costs.
- The model builds off the Next Generation Accountable Care Organization (ACO) Model and innovations from Medicare Advantage and private sector risk sharing arrangements.



# Risk Options

## Professional

- ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- 50% shared savings/shared losses with CMS
- **Primary Care Capitation (PCC)** equal to 7% of total cost of care for enhanced primary care services

## Global

- ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- 100% risk
- Choice between **Total Care Capitation (TCC)** equal to 100% of total cost of care provided by Participant and Preferred Providers, and PCC

## Geographic (proposed)

- Would be open to entities interested in taking on regional risk and entering into arrangements with clinicians in the region
- 100% risk
- Would offer a choice between **Full Financial Risk with FFS claims reconciliation** and TCC

← Lowest Risk

Highest Risk →

# Direct Contracting Model Timeframe

- Implementation Period (IP) in 2020 (optional)
  - IP provides time to engage in beneficiary alignment activities and plan care coordination and management strategies prior to the first performance year (PY1).
  - Model participants can also participate in other shared savings initiatives models such as the Medicare Shared Savings Program and Next Generation ACO Model, and other Innovation Center models.
- Five Performance Years (PYs) from 2021 through 2025
  - Model Payments begin in PY1 (2021).
  - Direct Contracting will be an **Advanced Alternative Payment Model (APM)**.
  - Model participants cannot participate in the Medicare Shared Savings Program or other shared savings initiatives.

# Model Participants

**A Direct Contracting Entity (DCE) is an ACO-like organization, comprised of health care providers and suppliers, operating under a common legal structure, which enters into an arrangement with CMS and accepts financial accountability for the overall quality and cost of medical care furnished to Medicare FFS beneficiaries aligned to the entity.**

## Standard DCEs

DCEs that have experience serving Medicare FFS beneficiaries.

## New Entrant DCEs

DCEs that have not traditionally provided services to a Medicare FFS population. Beneficiaries are aligned primarily based on voluntary alignment.

## High Needs Population DCEs

DCEs that serve Medicare FFS beneficiaries with complex needs employing care delivery strategies, such as those used by Program of All-Inclusive Care for the Elderly (PACE) organizations.

# Provider Relationships

## Direct Contracting Entity (DCE)

- Must have arrangements with Medicare-enrolled providers or suppliers, who agree to participate in the Model and contribute to the DCE's goals pursuant to a written agreement with the DCE.
- DCEs form relationships with two types of provider or supplier:

### DC Participant Providers

- Used to align beneficiaries to the DCE
- Required to accept payment from the DCE through their negotiated payment arrangement with the DCE, continue to submit claims to Medicare, and accept claims reduction
- Report quality
- Eligible to receive shared savings
- Have the option to participate in benefit enhancements or patient engagement incentives

### Preferred Providers

- Not used to align beneficiaries to the DCE
- Can elect to accept payment from the DCE through their a negotiated payment arrangement with the DCE, continue to submit claims to Medicare, and accept claims reduction
- Eligible to receive shared savings
- Have the option to participate in benefit enhancements and patient engagement incentives

# Financial Goals and Opportunities

- The Direct Contracting Model expands on the Next Generation ACO Model, introducing several new model design elements including:
  - **New benchmark methodologies** focused on increasing benchmark stability, simplicity and prospectively;
  - **Capitation and other advanced payment alternatives** for model participants; and
  - Financial model that **supports broader participation** by entities new to Medicare Fee for Service and/or focused on delivering care for high needs populations.

# Key Features of the Direct Contracting Performance Year Benchmark

**Direct Contracting will introduce several innovative methodologies to benchmark construction, including:**

## MA Rate Book

The DCE's Performance Year Benchmark will incorporate an adjusted version of the Medicare Advantage Rate Book.

## US Per Capita Cost (USPCC)

The DCE's Performance Year Benchmark will use the USPCC, developed annually by the Office of the Actuary (OACT), to establish the trend rate.

## Risk Adjustment

The DCE's Performance Year Benchmark will be adjusted to account for the risk of the population. CMS is exploring the possible application of a risk adjustment methodology that better addresses the costs experienced by complex and chronically ill populations.



# Payment Mechanisms

## The Thesis

Having control of the flow of funds with their downstream providers and suppliers will enable DCEs to improve care coordination and delivery, and to better manage the health needs of their aligned population, resulting in reduced costs and better outcomes.

**Direct Contracting offers DCEs several mechanisms to receive stable monthly payments.**

### Capitation Payment Mechanisms

DCEs receive a capitation payment covering total cost of care or cost of primary care services.

#### MANDATORY

Payment amount is **NOT RECONCILED** against actual claims expenditures.

### Advanced Payment

DCEs that select Primary Care Capitation may receive an advanced payment of their FFS non-primary care claims.

#### VOLUNTARY

Payment amount is **RECONCILED** against actual claims expenditures

# Capitation Payments

**DCEs must select one of the two Capitation Payment Mechanisms. The Capitation Payment Mechanisms available vary based on the Risk Option selected.**

- 1 Primary Care Capitation (PCC)** { Monthly capitation payments for primary care services furnished to aligned beneficiaries. *Available for Global and Professional*
- 2 Total Care Capitation (TCC)** { Monthly capitation payments for all services furnished to aligned beneficiaries. *Available for Global Only*

# Model Timeline

Timeline	Implementation Period (IP) DCE Applicants	Performance Period (PY1) DCE Applicants
<b>Application Period</b>	November 25, 2019 – February 25, 2020 (Application tool available December 20, 2019 [tentative])	March 2020 – May 2020
<b>DCE Selection</b>	April 2020	September 2020
<b>Deadline for applicants to sign and return Participant Agreement (PA)</b>	Late April 2020 (Implementation Period PA)  December 2020 (Performance Period PA)	December 2020
<b>Initial Voluntary Alignment Outreach and start of IP or PY</b>	May 2020	January 2021

***This timeline may be subject to change. Please check the Directing Contracting webpage for webinar and office hour dates and times.***

# Kidney Care Choices Model

# Kidney Care Choices (KCC) Builds on CEC Model

## Comprehensive ESRD Care (CEC) Model

- CEC Model began in October 2015 and will run through December 31, 2020.
- Accountable Care Organizations (ACOs) formed by dialysis facilities, nephrologists, and other Medicare providers and suppliers work together with the goal to improve outcomes and reduce per capita expenditures for aligned ESRD beneficiaries.
- Results for the Model showed lower spending relative to benchmark group and improvements on some utilization and quality measures.



## Kidney Care Choices (KCC) Model

- The KCC model will begin in 2020 and will run through 2023 with the option for CMMI to extend the Model for one or two additional years.
- Single set of providers and suppliers responsible for patient's care from CKD Stages 4,5 through dialysis, transplantation, or end of life care.

# Overview of the KCC Model Options

Payment Options	Overview	Participants
<b>CMS Kidney Care First (KCF) Option</b>	Based on the Primary Care First (PCF) Model – nephrology practices will be eligible to receive bonus payments for effective management of beneficiaries	Nephrologists/nephrology practices only
<b>Comprehensive Kidney Care Contracting (CKCC) Graduated Option</b>	Based on existing CEC Model One-Sided Risk Track – allowing certain participants to begin under a lower-reward one-sided model and incrementally phase in risk and additional potential reward	Must include nephrologists and nephrology practices; may also include transplant providers, dialysis facilities, and other kidney care providers on an optional basis
<b>CKCC Professional Option</b>	Based on the Professional Population-Based Payment option of the Direct Contracting Model – with 50% of shared savings or shared losses in the total cost of care for Part A and B services	
<b>CKCC Global Option</b>	Based on the Global Population-Based Payment option of the Direct Contracting Model – with risk for 100% of the total cost of care for all Part A and B services for aligned beneficiaries	

# Legal Structure of the KCF Option

**CMS Kidney Care First (KCF) Practice**



Nephrologists

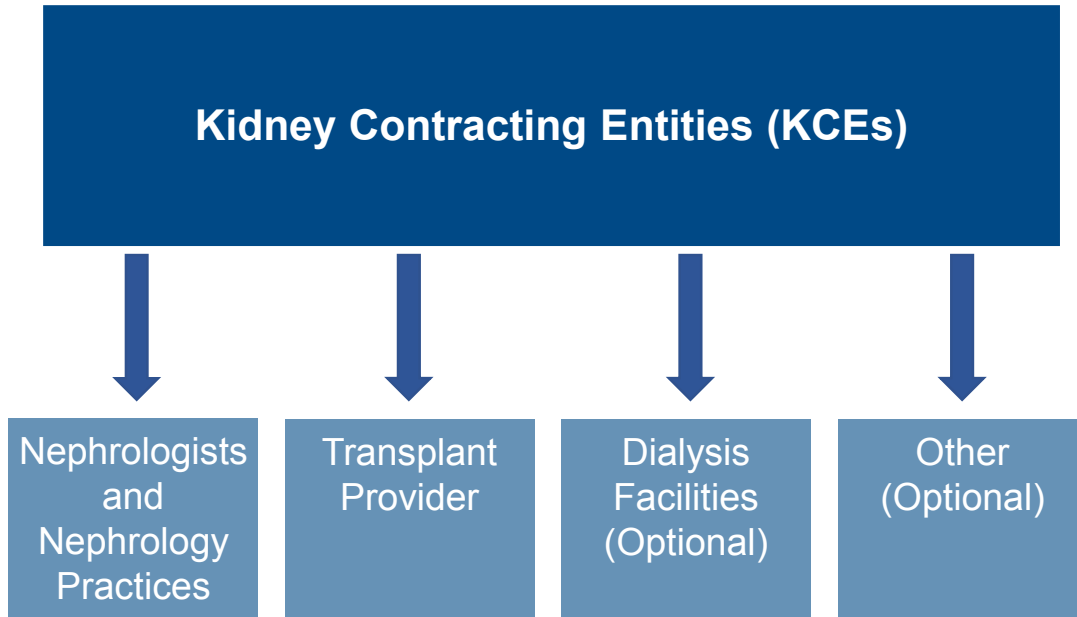


Nephrology Practices

## **Legal Entity & Contracting Requirements**

1. Must be able to receive the payments under the model from CMS.
2. Must demonstrate the ability to assume financial risk and make any required repayments to the Medicare program.
3. Must establish reporting mechanisms and ensuring compliance with program requirements, including but not limited to, reporting on quality measures.

# Legal Structure of the CKCC Options



**A KCE must include:** at least one nephrologist or nephrology group practice, and at least one transplant center, transplant surgeon, transplant nephrologist, and/or organ procurement organization (OPO).

## Legal Entity & Contracting Requirements

1. Receiving and distributing shared savings payments or payments received from CMS under the KCC model's alternative payment mechanisms.
2. Collecting and repaying shared losses, if applicable.
3. Establishing reporting mechanisms and ensuring KCC participant compliance with program requirements, including but not limited to reporting on quality measures.
4. Securing a financial guarantee, if applicable.



# Beneficiary Alignment Basics

## Alignment for CKD Stage 4 & 5 and ESRD Beneficiaries

- Beneficiaries are aligned to a KCE based on nephrologist visits.
  - This alignment method prioritizes the nephrologist relationship as the most important one for beneficiaries with advanced CKD or ESRD.
  - CMS believes this protects the continuity of care from treating a beneficiary with CKD 4 or 5 with the same nephrologist who would then be treating them if they progress to ESRD.
- Alignment will be based on beneficiary claims.

## Alignment for Transplant Beneficiaries

- When an aligned beneficiary receives a kidney transplant, they will remain aligned to the KCE for three years from the month of transplant, while the transplant is viable.
- If the transplant fails, the beneficiary may become aligned as a CKD or ESRD beneficiary.

# Key Payment Mechanisms

1. **Adjusted Monthly Capitated Payment (AMCP)**: capitated payment paid to model participants to managed ESRD, based on the MCP
2. **CKD Quarterly Capitated Payment (CKD QCP)**: capitated payment paid to model participants to manage CKD 4 / 5 patients
3. **Kidney Transplant Bonus (KTB)**: incremental reimbursement for successful kidney transplant
4. **Shared Savings / Losses** based on total cost of care compared to benchmark (available to CKCC option participants only)
5. **Performance Based Adjustment (PBA)**: upward or downward adjustment to the CKD QCP and AMCP based on participant's year-over-year continuous improvement and performance relative to peers (available to KCF practices only)

# KCF Performance Based Adjustment Overview

KCF includes: the **Quality Gateway** and the **Performance Based Adjustment (PBA)**

- **The Quality Gateway** is a quality threshold based on a set of measures that:
  - indicate appropriate clinical care and engagement for the patient population
  - are related to the beneficiary's kidney disease,
  - are applicable to both CKD stage 4 and 5 ESRD beneficiaries
- **Performance Based Adjustment (PBA)** are based on a calculation including both relative performance and continuous improvement on a set of quality measures covering utilization and safety

# Comprehensive Kidney Care Contracting (CKCC) Options Payment Summary

KCEs have the choice of 3 CKCC options with increasing opportunity for risk

## Graduated Risk Option

## Professional PBP Risk Option

## Global PBP Option

**Description:** KCEs will have one-sided risk in the first PY and then graduate to downside risk in the subsequent PYs. This option is based on the one-sided risk track in the CEC Model

KCEs will share in 50% of shared savings or losses in the total cost of care for Part A and B services

KCEs will be at risk for 100% of the total cost of care for Part A and B services

**Risk Sharing:** One sided, transitioning to two sided after 1 or 2 years

50% shared savings / losses

100% shared savings / losses

**Benchmark Discount:** None

None

3% for PY1 and PY2, increasing 1% each subsequent PY

**Eligible for Total Care Capitation:**

No

No

Yes

# KCC Model Timeline and Next Steps

## KCC Model Timeline:

- The Model is expected to run from 2020 through December 31, 2023, with the option for one or two additional performance years at CMS's discretion.
  - Selected health care providers begin model participation in 2020, though financial accountability will not begin until 2021.
  - During 2020, or the Implementation Period, model participants will focus on building necessary care relationships and infrastructure.
- Applications are due through January 22, 2020

More information will be available at [The KCC Model Website](#). Sign up via email and follow CMS on Twitter (@CMSinnovates).

# Comparison of the Three Models

# Model Comparison on Key Factors

The following table compares the three models discussed. See model websites for further detail.

	Primary Care First	Direct Contracting	Kidney Care First	Comprehensive Kidney Care Contracting
Eligibility	<p><b>PCF-General Component:</b> Primary care practices with advanced primary care capabilities prepared to accept increased financial risk in exchange for flexibility and potential rewards based on practice performance.</p> <p><b>SIP-Component:</b> Practices that demonstrate relevant capabilities and care experience to accept SIP patients that CMS identifies in their service area who express interest in the model.</p>	<p>Each Direct Contracting Entity (DCE) must contract with DC Participant Providers. DC Participant Providers may include, but are not limited to: physicians or other practitioners in group practice arrangements, networks of individual practices of physicians or other practitioners, and more.</p>	<p>Nephrologists and nephrology practices who comply with additional eligibility criteria may apply to participate.</p>	<p>Kidney Care Contracting Entities (KCEs) participating in the Comprehensive Kidney Care Contracting Options are required to include nephrologists or nephrology practices and transplant providers; while dialysis facilities and other providers and suppliers are optional participants in KCEs.</p>
Application Deadline	January 22, 2020	February 25, 2020	January 22, 2020	January 22, 2020
Model Launch	January 2021	January 2021	Spring 2020	Spring 2020

# Model Comparison on Key Factors (Cont.)

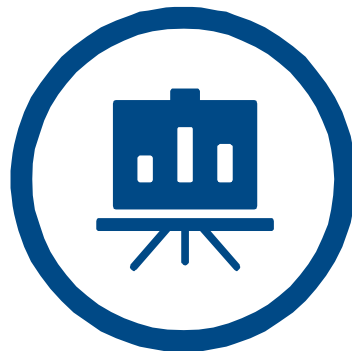
The following table compares the three models discussed. See model websites for further detail.

	Primary Care First	Direct Contracting	Kidney Care First	Comprehensive Kidney Care Contracting
Payment	<p>Primary care practices can participate in one of three payment model options:</p> <ol style="list-style-type: none"> <li>1) PCF-General Component;</li> <li>2) Seriously Ill Population (SIP) Component;</li> <li>3) Both PCF-General and SIP Components.</li> </ol> <p>For more detail on the components of each model option, see the model website.</p>	<p>Direct Contracting offers three options for participants to take on increasing levels of risk and potentially earn savings:</p> <ol style="list-style-type: none"> <li>1) Professional (50% risk)</li> <li>2) Global (100% risk)</li> <li>3) Geographic (proposed full risk for a geographic population)</li> </ol> <p>In addition, participants will have choices related to capitated payments, cash flow, beneficiary alignment, and benefit enhancements.</p>	<p>Participants will receive capitated payments for managing beneficiaries with late-stage CKD and ESRD, which will be adjusted based on quality performance and utilization. Participants will receive a bonus payment for every aligned beneficiary who receives a kidney transplant.<sup>1</sup></p>	<p>The model offers three options to provide increasing levels of risk and potential reward:</p> <ol style="list-style-type: none"> <li>1) Graduated Option;</li> <li>2) Professional Option;</li> <li>3) Global Option.</li> </ol>

<sup>1</sup>The full amount of the bonus payment will be paid out at set intervals provided the kidney transplant remains successful.



# Audience Poll



**Is your organization eligible to participate in any of the below models?  
Please select all that apply.**

- a) Primary Care First
- b) Direct Contracting
- c) Kidney Care Choices: Kidney Care First
- d) Kidney Care Choices: Comprehensive Kidney Care Contracting
- e) None
- f) Unsure

# Questions



## Open Q&A

For questions **specific to your organization**, please **email**:

Primary Care First: [PrimaryCareApply@telligen.com](mailto:PrimaryCareApply@telligen.com)

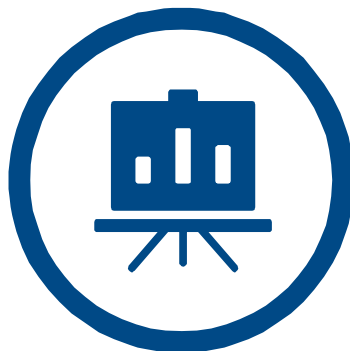
Direct Contracting: [DPC@cms.hhs.gov](mailto:DPC@cms.hhs.gov)

Kidney Care Choices: [KCF-CKCC-CMMI@cms.hhs.gov](mailto:KCF-CKCC-CMMI@cms.hhs.gov)

Please submit questions via the Q&A pod on the right side of your screen.



# Audience Poll



**What model topics would you like to learn more about before applying to a model?**

- a) Application submission
- b) Participation requirements/eligibility
- c) Model payment structure and quality measures
- d) N/A; My organization has already submitted our application and/or needs no more information

# Resources and Contact Info

Use the following resources to learn more about the Primary Care First, Direct Contracting, and Kidney Care Choices Models.

## Model Websites

[Primary Care First](#)

[Direct Contracting](#)

[Kidney Care Choices](#)

## Subscribe

[CMS Innovation Center Listserv](#)

## Email

Primary Care First: [PrimaryCareApply@telligen.com](mailto:PrimaryCareApply@telligen.com)

Direct Contracting: [DPC@cms.hhs.gov](mailto:DPC@cms.hhs.gov)

Kidney Care Choices: [KCF-CKCC-CMMI@cms.hhs.gov](mailto:KCF-CKCC-CMMI@cms.hhs.gov)

## Request for Applications

[Primary Care First RFA](#)

[Direct Contracting RFA](#)

[Kidney Care Choices RFA](#)