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, Comprehensive Kidney Care Contracting (CKCC) Graduated Option, CKCC Professional Option, and the CKCC Global Option.

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

Who is participating in the Model?

Four CMS Kidney Care First (KCF) Practices and 50 Kidney Contracting Entities (KCEs) are starting their participation in the KCC Model beginning in Performance Year 2023 (PY2023), which started January 1, 2023. These KCC entities join 26 KCF Practices and 50 KCEs continuing in the model from PY2022 to PY2023 for a total of 30 KCF Practices and 100 KCEs. The KCC entities will serve Medicare fee for service beneficiaries in 47 states as well as in the District of Columbia. Twenty-seven of the KCEs have selected the Global Option, 14 have selected the Professional Option, and 9 have selected the Graduated Option (Level 1 or Level 2).

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. Under the Model, a single set of kidney care providers is responsible for a patient's kidney care from the late stage of CKD through dialysis and post-transplant care. A nephrology practice –the Kidney Care First practice (KCF practice) in the KCF Option– or a group of health care providers—the Kidney Contracting Entity (KCE) in the CKCC Options – 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 KCF practices and KCEs to furnish care that meets beneficiaries' health needs by incentivizing them to best guide their aligned beneficiaries through the course of their CKD stage 4 or 5 or ESRD. In particular, KCF practices and 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), increased 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 testing the KCC Model?

The KCC Model Performance Period began on January 1, 2022, and will continue through December 31, 2026. CMS solicited applications for the first cohort of KCC Model participants in October 2019. Healthcare providers interested in participating in the first cohort of KCC Model participants were required to apply by January 22, 2020. Applicants selected for participation had the option to participate in an Implementation Period, which began 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 February 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?

The CMS Kidney Care First Option is open to nephrology practices and their nephrologists only, subject to meeting certain eligibility requirements.

KCEs participating in one of 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.

How will beneficiaries be aligned to the Model?

The beneficiary alignment process is the same for the KCF and CKCC Options. Alignment is based on beneficiary claims. Beneficiaries who meet the following criteria will be eligible to be aligned or remain aligned to KCF practices or KCEs:

- Medicare beneficiaries with CKD stages 4 and 5.
- Medicare beneficiaries with ESRD receiving maintenance dialysis.
- Medicare beneficiaries who were aligned to a KCF practice or 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 his or her kidney care. When an aligned beneficiary receives a kidney transplant, he or she will 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 he or she meets the requirements for alignment by virtue of his or her ESRD.

What is the payment methodology for the CMS Kidney Care First Option?

In the CMS KCF Option, participating nephrologists and nephrology practices receive quarterly capitated payments for managing care of aligned beneficiaries with CKD Stages 4 or 5 and adjusted monthly capitated payments for ESRD patients. These payments are adjusted on the basis of quality and utilization measures and by comparing a participant’s performance to other participants and the participant’s past

performance. In addition, KCF practices receive a bonus payment for every aligned beneficiary who receives a kidney transplant, with the full amount of the bonus paid over three years following the transplant provided the transplant remains successful.

What is the payment methodology for the Comprehensive Kidney Care Contracting Options?

As in the KCF Option, KCEs receive adjusted payments for managing beneficiaries with CKD Stages 4 and 5, and ESRD, along with the kidney transplant bonus payment.

The CKCC Options have three distinct accountability frameworks:

CKCC Graduated Option: Allows certain participants to begin under a lower-reward one-sided model or lower-risk two-sided model and incrementally phase in to greater risk and greater potential reward. Participants will graduate to the Professional Option in one or two years.

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: Requires entities to be at 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 so as 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 KCF practices and KCEs qualify as Alternative Payment Model (APM) Entities?

KCF practices and KCEs in the CKCC Professional or Global Option will qualify as Advanced APM entities2022, assuming that they meet the payment or patient thresholds required under the Quality Payment Program. The one-sided risk track (Level 1) of the CKCC Graduated option will not qualify as an Advanced APM2022 but does qualify as a Merit-Based Incentive Payment System (MIPS) APM, while, the Graduated Risk Option (Level 2) will be considered an Advanced APM.

Are there any Medicare benefit enhancements under the Model?

Participants in the KCC Model may select to offer one or more of the following benefit enhancements:

- Kidney Disease Education benefit – Medicare currently covers up to six 1-hour sessions for beneficiaries with stage 4 CKD. This benefit enhancement allows additional categories of practitioners o to provide this service and allows services to be furnished to beneficiaries with stage 5 CKD and those in the first 6 months of starting dialysis.

- Telehealth – Telehealth services may be utilized for populations not classified as rural, thus providing flexibility for beneficiaries to communicate with their providers and suppliers when necessary and medically appropriate, including in their own home.

- 3-day skilled nursing facility (SNF) rule – CMS has waived the requirement that beneficiaries complete a 3-day stay at an inpatient facility prior to being eligible for SNF admission if certain criteria are met.

- Post-discharge home visit – Auxiliary personnel may furnish in-home services to aligned beneficiaries after a discharge from a hospital under the general, rather than direct, supervision of a physician or non-physician practitioner.

- Care management home visit – Home visits for the purposes of care management.

- Home Health – Eligible beneficiaries who are not “confined to the home” may receive coverage for that a beneficiary be confined to his or her home certain home health services, expanding the situations in which certain beneficiaries could receive home health services.

- Hospice: would be allowed Waives the requirement that beneficiaries aligned to a participating KCE forego curative care as a condition of Medicare coverage of hospice care if certain criteria are met.

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 quality of care and quality of life, and Medicare expenditures and utilization. The implementation component will describe and assess how participants implement the features of 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 potential the Actuary’s certification and the HHS Secretary’s determinations on model expansion, in accordance with Sec. 1115A(c) [42 U.S.C. 1315a].