

HHS Fact sheet

Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) Models

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Overview

The Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) Graduated, Professional, and Global Models will build upon the existing 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 to manage care for beneficiaries with ESRD – 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, to delay the onset of dialysis and to incentivize kidney transplantation. The design of these models likewise draws from the recently announced Primary Care First and Direct Contracting models.

Will participation in the KCF and CKCC Models be required for health care providers?

Participation is optional for health care providers.

What are the models' goals and how will the models achieve these goals?

The models are designed to incentivize better management of kidney disease. A single set of kidney care providers will be 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 model – or a group of health care providers—the Kidney Contracting Entity (KCE) in the CKCC models – will be responsible for aligned beneficiaries' kidney care from the late stage of CKD or ESRD through dialysis, kidney transplantation, and post-transplant care. Each Model will utilize 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 will 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 Models' design. The tendency now is for patients with kidney disease to follow the most expensive 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 Models will avoid 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 will these models build upon the CEC model?

These models build on key lessons and areas for improvement recognized during the first 3 years of the current 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 KCF and CKCC Models?

The Models are expected to run from January 1, 2020, through December 31, 2023, with the option for one or two additional performance years at CMS's discretion. Health care providers interested in participating will apply to participate in the fall of 2019, and if selected, begin model participation in 2020. However, financial accountability will not begin until 2021. During 2020, or Year 0, model participants will focus on building necessary care relationships and infrastructure.

Who is eligible to participate in the Models?

The Kidney Care First Models will be open to participation by nephrology practices and their nephrologists only, subject to meeting certain eligibility requirements. KCEs participating in the Comprehensive Kidney Care Contracting Models 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 will be the same for the KCF and CKCC Models. Beneficiaries who meet the following criteria will be eligible to be aligned to these Models:

- 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 will take into consideration 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 will be the payment methodology for the Kidney Care First Model?

In the KCF Model, participating nephrologists and nephrology practices will receive adjusted capitated payments for managing care of aligned beneficiaries with CKD Stages 4 or 5, and for those on dialysis. These payments will be adjusted on the basis of health outcomes and utilization compared to both the participants' own experience and national standards, and also performance on quality measures. In addition, KCF practices will 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 will be the payment methodology for the Comprehensive Kidney Care Contracting Models?

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

The CKCC Models will have three distinct accountability frameworks:

- CKCC Graduated Model: This model is based on the existing CEC Model One-Sided Risk Track – allowing certain participants to begin under a lower-reward one-sided model and incrementally phase in to greater risk and greater potential reward.
- CKCC Professional Model: This payment arrangement is based on the Professional Population-Based Payment option of the Direct Contracting Model – with 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 Model: This payment arrangement is 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 Parts A and B services for aligned beneficiaries.

Together, these models aim 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 is establishing 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?

The KCF model and the CKCC Professional and Global Models are expected to qualify as Advanced APMs beginning in 2021. Participating KCF practices can therefore qualify as APM Entities participating in an Advanced APM beginning in 2021, assuming that they meet the payment or patient thresholds required under the Quality Payment Program.

KCEs participating under the CKCC Professional and Global Models will also qualify as APM Entities participating in an Advanced APM beginning in 2021. KCEs in the CKCC Graduated Model will qualify as APM Entities once they move to the CKCC Professional Model.

Will there be any Medicare benefit enhancements under the models?

CMS is exploring these Medicare benefit enhancements for the Model:

- *Kidney Disease Education benefit* – Medicare currently covers up to six 1-hour sessions for beneficiaries with stage 4 CKD. The model would allow practitioners other than currently permitted clinicians to provide this service, as well as would allow the service to be furnished to beneficiaries with stage 5 CKD and certain beneficiaries with ESRD.
- *Telehealth* – Telehealth services would be allowed to 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.
- *3-day skilled nursing facility (SNF) rule* – The model would waive the requirement that beneficiaries complete a 3-day stay at an inpatient facility prior to being eligible for SNF admission.
- *Post-discharge home visit* – Auxiliary personnel would be able to 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 would also be allowed for the purposes of care management.
- *Home Health* – The “confined to his home” requirement for utilizing home health services would be waived.

How will the Models be evaluated?

An independent evaluation will be conducted for each of the models. 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 potentially five-year 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 Models 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 [42 U.S.C. 1315a].

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